Supreme Court, U.S.
FILED

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No.

IN THE

Supreme Court of the United States

JANIS L. BROWN, INDIVIDUALLY, AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF JASON RAY BROWN, DECEASED; BILLY RAY BROWN, PETITIONERS

v.

THOMAS J. CALLAHAN, SHERIFF OF WICHITA COUNTY, TEXAS, IN HIS INDIVIDUAL AND OFFICIAL CAPACITY

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Fifth Circuit reversed the District Court's ruling denying Sheriff Callahan's Motion for Summary Judgment filed on February 29, 2008, on the issue of qualified immunity.

Three questions are presented:

1. Whether unlawful medical care is a violation of a pretrial detainee's Fourteenth Amendment right to not have their serious medical needs met with deliberate indifference by jail officials.

2. Whether Petitioners raised sufficient summary judgment evidence to overcome Sheriff Callahan's affirmative defense of qualified immunity based on Petitioners' allegation that Sheriff Callahan failed to train and/or supervise Dr. Bolin and the jail nurses.

3. Whether Petitioners raised sufficient summary judgment evidence to overcome Sheriff Callahan's affirmative defense of qualified immunity based on Petitioners' allegation that Sheriff Callahan adopted jail policies or procedures with deliberate indifference.

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The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 623 F.3d 249 (Oct. 7, 2010). The opinion of the United States District Court for the Northern District of Texas, Wichita Falls Division (Aug. 4, 2009), was not selected for publication in the Federal Reporter.

JURISDICTION

The decision of the United States Court of Appeals for the Fifth Circuit, reversing the District Court's denial of Sheriff Callahan's Motion for Summary Judgment on the issue of qualified immunity, was handed down on October 7, 2010. The Petitioners' Petition for Rule 40 Panel Rehearing was denied on November 18, 2010. This Court has jurisdiction pursuant to 28 U.S.C. §1254(1).

RELEVANT PROVISIONS INVOLVED

42 U.S.C. §1983:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

STATEMENT

Janis Brown and Billy Ray Brown (collectively the "Petitioners") have brought claims pursuant to 42 U.S.C. §1983 against Dr. Daniel H. Bolin ("Dr. Bolin"), Wichita County, Texas (the "County"), Sheriff Thomas J. Callahan ("Sheriff Callahan"), and Nurse Kaye Krajca ("Nurse Krajca") for violating Jason Ray Brown's ("Decedent") constitutional rights flowing from the due process guarantees of the Fourteenth Amendment to the United States Constitution while a pre-trial detainee in the Wichita County Jail (the "Jail") from July 22, 2004 to July 24, 2004. In particular, Petitioners have brought suit against Dr. Bolin, the County, Sheriff Callahan, and Nurse Krajca for failing to provide adequate medical care to Decedent when he exhibited objectively verifiable symptoms of a massive gastrointestinal hemorrhage that called for immediate medical attention, and instead placed Decedent in a Medical Solitary Cell to suffer for over 20 *HOURS* and to ultimately die alone.

A. The Incident

On or about July 22, 2004, Decedent was arrested in Burkburnett, Texas and was transported to the Jail at approximately 4:00 p.m. (USCA5, p. 29). At that time, Dr. Bolin served as the contracting physician and one of the supervisors of the nursing staff at the Jail. (USCA5, p. 2991). Nurse Krajca, Michelle George ("Nurse George"), and Rose Ingram ("Nurse Ingram") served as the Jail nursing staff. (USCA5, p. 2991). At the time of his booking into the Jail, Decedent had informed various Jail officials of his medical problems including high blood pressure, autoimmune chronic

hepatitis, esophageal varices, jaundice, spleenial megaly, cirrhosis of the liver, and anemia. (USCA5, Vol. 10, Jt. App. 159). At the time of his book-in, detention officers reported that Decedent was complaining of not feeling well and of throwing up blood. (USCA5, p. Vol. 10, Jt. App. 160). Nurse George allegedly attempted to contact Decedent's treating physician, Dr. Joe Dean, but was purportedly unable to contact him. (USCA5, Vol. 10, Jt. App. 161). Nurse George then allegedly contacted Decedent's pharmacy and was fully advised of his medications and reportedly that he had not picked them up since January 2004. (USCA5, Vol. 10, Jt. App. 161). At that time, Nurse George decided, with the approval of her supervisor, Nurse Ingram, to "hold off until seen by Dr. Bolin in sick-call". (USCA5, Vol. 10, Jt. App. 161). This decision was made even though Nurse George and Nurse Ingram knew that all of Decedent's medications were to be taken anywhere from once a day to three times a day. (USCA5, Vol. 10, Jt. App. 160 - Jt. App. 161).

Over 31 *HOURS* later, inmates in Tank 7/6 contacted the control room by the emergency button and informed detention officers that Decedent had thrown up blood "all over the floor". (USCA5, Vol. 10, Jt. App. 162). Detention Officer Dickey Lee Sours, Jr. ("Officer Sours") reported to the cell and observed a puddle of blood next to Decedent that was "1 to 1.5 feet in width to 2 to 2.5 foot in length". (USCA5, Vol. 10, Jt. App. 162). Decedent had previously informed Officer Sours and Blaine Greene ("Officer Greene") that "he had gastric ulcers ... takes $1,300.00 of medications a month ... took high blood pressure meds, Prezadone ... and had 27 units of blood transfusions since Super Bowl Sunday of 2003". (USCA5, Vol. 10, Jt. App. 162; Vol. 10,

Jt. App. 170). At this point in time, Nurse Krajca was called at home by the control room officer and was told of the situation. (USCA5, Vol. 10, Jt. App. 162; Vol. 10, Jt. App. 170).

Without being physically present at the Jail, and without even having seen the condition of Decedent, unbelievably, Nurse Krajca prescribed "1 tube Alamag [a liquid antacid] per our standing orders". (USCA5, Vol. 10, Jt. App. 162; Vol. 10, Jt. App. 183). Decedent "kept complaining that he wasn't feeling very good and that he was in a lot of pain". (USCA5, Vol. 10, Jt. App. 170).

At some point between midnight and 2:00 a.m., the inmates of Tank 7/6 again called Officer Sours and reported that Decedent "was in a lot of pain and was begging for help". (USCA5, Vol. 10, Jt. App. 162; Vol. 10, Jt. App. 170). This time, Officer Sours personally went to the control room and talked to Nurse Krajca on the phone. (USCA5, Vol. 10, Jt. App. 162). When asked by Nurse Krajca if anyone had actually seen Decedent throw up blood, Officer Sours responded "KAYE, I had to clean it up". (USCA 5, Vol. 10, Jt. App. 162). During this same phone call, Officer Sours also reported that "he was supposed to see Dr. Dean (gastroenterologist) before coming to Jail; but he never did". (USCA5, Vol. 10, Jt. App. 183). As her next remedy, Nurse Krajca prescribed "a Phenergan suppository for nausea per Dr. Bolin's standing orders". (USCA5, Vol. 10, Jt. App. 183). Officers Sours and Greene attempted to administer the suppository but reportedly could not do so because Decedent was "not coherent". (USCA5, Vol. 10, Jt. App. 162; Vol. 10, Jt. App. 170). Decedent "kept moaning and saying that he was in a lot of pain". (USCA5, Vol. 10, Jt. App. 170). At approximately 2:25

a.m., Officers Sours and Greene again called Nurse Krajca to inform her that they were unable to administer the suppository because Decedent was "not coherent". (USCA5, Vol. 10, Jt. App. 162; Vol. 10, Jt. App. 170).

Nurse Krajca *FINALLY* arrived at the Jail at 2:55 a.m. to find Decedent still incoherent and in a state of distress. Nurse Krajca "couldn't get Inmate Brown to respond by talking to him" so she checked his eyes and pressed on his fingernail cuticles. (USCA5, Vol. 10, Jt. App. 162). At approximately 3:12 a.m., Nurse Krajca had Decedent taken to a Medical Solitary Cell (i.e., a solitary cell away from the other inmates who were taking care of Decedent). (USCA5, Vol. 10, Jt. App. 162; Vol. 10, Jt. App. 170; Vol. 10, Jt. App. 183). On the way to the Medical Solitary Cell, Nurse Krajca reported seeing Decedent "cough up a small amount of coffee ground emesis". (USCA5, Vol. 10, Jt. App. 183). Once inside Medical Solitary Cell S-3, Nurse Krajca instructed Officers Sours and Greene to pick up Decedent and bend him over so that she could administer the suppository. (USCA5, Vol. 10, Jt. App. 170). Nurse Krajca's notes reflect that Decedent did not want the suppository, but instead asked to go to the E.R. (USCA5, Vol. 10, Jt. App. 185). Nurse Krajca stated she then told Decedent to "stay laying down because the suppository may make him drowsy". (USCA5, Vol. 10, Jt. App. 183).

The extent of "nursing care" administered by Nurse Krajca to Decedent was to place him on 30 minute observation and leave him completely alone in the Medical Solitary Cell with no other specific medical personnel on site, and return back home. (USCA5, Vol.

10, Jt. App. 170). Before leaving the Jail, Nurse Krajca enjoyed a cigarette and stated to Officer Sours:

> "Do you know what kind of ass-chewing I would get from Dr. Bolin if I sent him to the hospital in the good health he is in?" (USCA5, Vol. 10, Jt. App. 163).

Decedent remained in the Medical Solitary Cell for the next 20 *HOURS*, groaning and complaining of pain. (USCA5, Vol. 10, Jt. App. 186-187). Several Jailers, including Defendants Yeager, Whatley, Geary, Dickerman and Parish, allegedly checked in on Decedent through the cell door "bean hole". (USCA5, Vol. 10, Jt. App. 186-187). Not one time during the 20 *HOURS* of suffering endured by Decedent did one Jail official take his vitals or actually step foot into the Medical Solitary Cell to check on his medical condition. (USCA5, Vol. 10, Jt. App. 186-188).

Instead, Decedent's "medical care" consisted of the following:

> (a) During the First Shift, the shift from 7:00 a.m. to 3:00 p.m., Yeager and Dickerman observed Decedent moaning and groaning. Yeager reported that "[a]t one check in the morning, I heard I/M Brown make a moaning sound while laying on his bunk". (USCA5, Vol. 10, Jt. App. 186). Dickerman reported that "[w]hen D.O. Yeager and I tried to feed I/M Brown at approximately 11:30hrs, I opened the bean hole and called into the Medical Solitary [Cell] to tell inmate it was time to eat. At first inmate just barely groaned. I asked again and

he groaned louder. I asked one more time to see if he wanted to eat and inmate turned his head and said what seemed to me to say no". (USCA5, Vol. 10, Jt. App. 187).

(b) During the Second Shift, the shift from 3:00 p.m. to 11:00 p.m., D.O. Whatley reported slight movements from Decedent. (USCA5, Vol. 10, Jt. App. 188). He also reported that Decedent's "door sheet" reflected that he was put in the Medical Solitary Cell at 3:12 a.m. but gave "no reason or specific illness". (USCA5, Vol. 10, Jt. App. 188). Whatley also reported that "[w]e received no pass-on for I/M Brown. First info we had of his condition was @ shift change when D.O. Ryan was checking SOL#3 and D.O. Mello asked him what the deal was with Brown. D.O. Ryan replied "he had passed a large amount of blood". (USCA5, Vol. 10, Jt. App. 188).

(c) At the end of the Second Shift a Jail laundry trustee, Brian Horwitz, was inadvertently provided access to Decedent's Medical Solitary Cell to use the bathroom. (USCA5, p. Vol. 10, Jt. App. 189). Mr. Horwitz stated as follows: "The door opened and I noticed the inmate was purple and pale but Mr. Parrish closed the door quickly and I looked in again and saw this inmate with his pants off and his left arm dangling to the floor and his head turned to the right. I told Mr. Parrish this person did not look right and he said nothing, and told me to go into S-5 to use the bathroom. (USCA5, Vol. 10, Jt. App. 189). At no time did I see Mr. Parrish go back to check on the person in S-3". (USCA5,

> Vol. 10, Jt. App. 189). "After shift change an officer checked on this person in S-3 and discovered him not breathing or alive. (USCA5, Vol. 10, Jt. App. 189). I also heard a comment that medical did not adhere to this persons' repeated requests to have something done other than a pink card and malocks and fill out a pink card and maybe get your guts back". (USCA5, Vol. 10, Jt. App. 189).

During the Third Shift Decedent was found unresponsive and pulseless by Officers Greene and Ryan. (USCA5, Vol. 10, Jt. App. 190). Decedent's arm was still "dangling over the side" of the bed. (USCA5, Vol. 10, Jt. App. 190). Upon discovery of Decedent's body, Officers Greene and Ryan notified Lt. Enos who started making phone calls. (USCA5, Vol. 10, Jt. App. 190). At around 11:30 p.m., Nurse Krajca received a phone call from Lt. Enos stating that "the inmate was unresponsive, without vital signs". (USCA5, Vol. 10, Jt. App. 183).

Ultimately, *55 HOURS* after Decedent made his first complaint of throwing-up blood, Nurse Krajca advised the detention officers to "call 911" after he is found unresponsive and pulseless. (USCA5, Vol. 10, Jt. App. 183). American Medical Response arrived at 11:57 p.m. and reported "Adv. Jail personnel that last date subj was spitting up blood and Jail nurse gave subj some type of suppository" and "subject appeared to have been U.U.P.A. [unconscious, unresponsive, pulseless, adneil] for quite some time". (USCA5, Vol. 10, Jt. App. 200-202).

B. Cause of Death

The Tarrant County Medical Examiner's Report summarizes the cause of Decedent's tragic death. Decedent died from a "massive gastrointestinal hemorrhage" due to rupture of the esophageal varices caused by chronic viral hepatitis with cirrhosis of the liver. (USCA5, Vol. 10, Jt. App. 219).

C. Post Incident Investigation

An investigation was conducted by Lt. David Duke into the facts and circumstances surrounding Decedent's death. Amazingly, the investigation did not involve Dr. Bolin and/or Nurse Ingram being interviewed to determine whether the Jail staff provided adequate medical care or followed the County's medical policies and procedures. (USCA5, Vol. 10, Jt. App. 203-210). Instead the investigation supported the fact that Nurse Krajca, a Licensed Vocational Nurse, was allowed to prescribe antacids and suppositories over the telephone because these procedures complied with the "standing orders" of Dr. Bolin, her boss, and would ensure that she did not receive an "ass-chewing" from him for sending Decedent to the hospital. (USCA5, Vol. 10, Jt. App. 208-210).

D. Procedural Standing

After conducting extensive discovery, on August 2, 2007, Dr. Bolin moved for summary judgment. (USCA5, p. 350-487). The Browns filed their response to Dr. Bolin's motion on August 28, 2007. (USCA5, p. 493-889). Thereafter Sheriff Callahan, the County,

Nurse Krajca and the Browns' jointly filed their respective motions for summary judgment, responses and joint appendices on February 29, 2008. (USCA5, p. 1291-1608; 1609 - Vol. 11, Jt. App. 649).

On April 9, 2008, the District Court filed its Memorandum Opinion and Order granting summary judgment on behalf of Dr. Bolin. (USCA5, p. 2770-2779). On April 9, 2008, the Browns filed their Motion for Reconsideration of the Court's Granting Bolin's Motion for Summary Judgment and Motion for Leave (USCA5, p. 2782-2836).

On May 20, 2008, the District Court granted in part and denied in part the summary judgment motion filed by Nurse Krajca. (USCA5, p. 2962-2973). On August 5, 2008, the District Court filed its Memorandum Opinion and Order denying the Browns' Amended Motion for Reconsideration of the order granting Dr. Bolin's Motion for Summary Judgment. (USCA5, p. 2985-2989). On August 6, 2008, the District Court issued its Memorandum Opinion and Order (USCA5, p. 2990-3007) and Final Judgment (USCA5, p. 3008-3009) granting the County's Motion for Summary Judgment. The Browns filed their Notice of Appeal from these orders on September 4, 2008. (USCA5, p. 3010-3013). On June 30, 2009, this Court filed its Summary Calendar [decision and opinion] (USCA5, p. 3028-3030) and its Judgment (USCA5, p. 3031-3032) dismissing the Browns' appeal for lack of jurisdiction.

On August 4, 2009, the District Court issued its Memorandum Opinion and Order granting in part and denying in part Sheriff Callahan's Motion for Summary Judgment (USCA5, p. 3036-3060). On August 4, 2009,

the District Court *sua sponte* reconsidered its previous granting of Dr. Bolin's summary judgment and issued its Memorandum Opinion and Order granting in part and denying in part Dr. Bolin's Motion for Summary Judgment (USCA5, p. 3061-3072). On August 4, 2009, the District Court issued its Order vacating its prior Order dated August 6, 2008, granting the County's Motion for Summary Judgment (USCA5, p. 3073-3074). On August 4, 2009, the District Court issued its Amended Memorandum Opinion and Order granting in part and denying in part the County's Motion for Summary Judgment (USCA5, p. 3075-3084). Sheriff Callahan filed his Notice of Appeal from these orders on August 20, 2009. (USCA5, p. 3120-3121). Dr. Bolin filed his Notice of Appeal from these orders on September 2, 2009. (USCA5, p. 3135-3136). On December 22, 2009, the Fifth Circuit Court of Appeals issued its Order dismissing Dr. Bolin's appeal for want of prosecution for failing to file his Brief.

On October 7, 2010, the Fifth Circuit Court of Appeals filed its Opinion reversing the District Court's denial of Sheriff Callahan's Motion for Summary Judgment based upon the defense of qualified immunity. On October 29, 2010, Petitioners filed their Petition for Rule 40 Panel Rehearing. On November 18, 2010, the Fifth Circuit Court of Appeals denied Petitioners' Petition for Rehearing.

REASONS FOR GRANTING THE PETITION

This Court should grant this Petition to resolve the issue of whether UNLAWFUL medical care is a violation of a pretrial detainees Fourteen Amendment right to not have their serious medical needs met with

deliberate indifference by jail officials. Additionally, this Court should grant this Petition because the Fifth Circuit did not apply the appropriate standard of review of the evidence to Sherriff Callahan's defense of qualified immunity, which requires all inferences to be drawn in favor of the non-movant. Petitioners have produced ample evidence supporting their claims that Sheriff Callahan is individually liable to the Petitioners for the death of their son under U.S.C.A. §1983 in his supervisory capacity because Sheriff Callahan (1) allowed nurse intimidation to flourish at the Jail; (2) allowed the Jail nurse staff to practice medicine and prescribe medications in violation of state law; and (3) failed to train and supervise the Jail nurse staff which resulted in Nurse Krajca violating Decedent's constitutional right to adequate medical care while a pre-trial detainee, resulting in his death.

A. Unlawful medical care is a violation of a pretrial detainee's Fourteenth Amendment right to not have their serious medical needs met with deliberate indifference by jail officials.

It is clearly established law that pretrial detainees have a Fourteenth Amendment right to not have their serious medical needs met with deliberate indifference by jail officials. *Hare v. City of Cornith, Miss.*, 74 F.3d 633, 650 (5th Cir. 1996). Accordingly, a pretrial detainee is entitled to medical care to treat his/her serious medical needs. Subjecting pre-trial detainees to unlawful medical care is facially unconstitutional as it amounts to no medical care at all.

The Fifth Circuit, in Footnote 3 of its Opinion, briefly addresses this issue and apparently requires a history of problems arising from the unlawful medical care in order to make the claim actionable. The Fifth Circuit stated: "[t]he record does not show any past incidents when a detainee died or suffered grievous harm because nursing staff failed to properly assess the severity of the detainee's symptoms." Petitioners respectfully disagree with the Fifth Circuit's position. Supervisory liability may exist without an official's overt personal participation in a direct offensive act where an official implements, adopts, or maintains a custom or policy that is so deficient that the policy itself if s a repudiation of constitutional rights and is the moving force of a constitutional violation. See *Cozzo v. Tangipahoa Parish Council-President Gov't*, 279 F.3d 273, 289 (5th Cir. 2002). If a policy exists and is violated to cause a constitutional violation, a single application of that policy can result in liability. *Oklahoma City v. Tuttle*, 471 U.S. 808, 820-24, 105 S.Ct. 2427, 2435-36, 85 L.Ed.2d 791 (1985).

As set forth more fully below, the County, through Dr. Bolin and Sherriff Callahan, established a policy of providing unlawful medical care to pretrial detainees such as Decedent. Based on the holding in *Tuttle*, if a Jail nurse such as Nurse Krajca follows the unlawful policy in providing so-called medical care outside the scope of her license, and it results in a constitutional violation, then a supervisor such as Sherriff Callahan can be held liable for such single violation without reference to previous incidents. In the case of Decedent, the uncontroverted evidence demonstrates that Nurse Krajca's performing duties outside the Texas Nurse Practices Act and Texas law

for prescribing medications were causally related to the death of Decedent. Sherriff Callahan, as a policy maker for the County Jail, is liable for the death of Decedent in his supervisory capacity.

B. Petitioners raised sufficient summary judgment evidence to overcome Sheriff Callahan's affirmative defense of qualified immunity based on Petitioners' allegation that Sheriff Callahan failed to train and/or supervise Dr. Bolin and the jail nurses.

Respondents produced ample uncontroverted evidence that the Jail's medical care system was being run by under-trained and unqualified Licensed Vocational Nurses ("LVN's"). Dr. Bolin and Sherriff Callahan implemented serious, unconstitutional policies through a substantial lack of interest, lack of training, lack of supervision, lack of participation and lack of presence. The woefully unsupervised, under-trained, under-skilled LVN's were responsible for all essential aspects of inmate healthcare at the Jail in 2004. Dr. Bolin and Sheriff Callahan made vocational nurses, including Nurse Krajca, responsible for:

(1) Assessing patients – just like a doctor (USCA5, Vol. 10, Jt. App. 294-296; 298-300); and

(2) Prescribing and administering medications – just like a doctor (USCA5, Vol. 10, Jt. App. 296-297).

These LVN's, with one (1) year of classroom instruction, were given the power and authority of a medical doctor, but with no supervision or meaningful professional boundaries. (USCA5, Vol. 11, Jt. App. 419-429; 430-443; 444-449; 550-558).

Petitioners' uncontroverted expert testimony establishes that the customs and practices of the County in providing medical care to inmates in 2004 were not only unlawful, but created a very dangerous environment for inmates that were in need of emergency medical care. Petitioners have produced expert testimony that the County, through Dr. Bolin and Sheriff Callahan, had a custom, pattern and practice of allowing undereducated and inadequately trained LVN's to assess, diagnose, prescribe medication, act as on-call nurses and make final treatment decisions. (USCA5, Vol. 11, Jt. App. 419-429; 430-443; 444-449; 550-558). Specifically, Petitioners have produced expert testimony that Dr. Bolin's and the County's custom and practice of delegating authority to LVN's to diagnosis inmates and administer over-the-counter drugs and prescription medications exceeded the Jail Nursing Staffs' scope of authority in violation of the Texas Nurse Practices Act and Texas law for prescribing medications. *Id.* It is uncontroverted that the County had a policy of requiring the Jail nurse staff, such as Nurse Krajca, to handle medical issues that were well outside their area of practice and what is permissible under Texas law. Sheriff Callahan has not attempted to dispel the fact that Dr. Bolin's prescription drug standing order was illegal under Texas law or to further attempt to argue that the actions taken by the LVN's were appropriate under the Texas Nurse Practices Act or under state

law. Subjecting pre-trial detainees to unlawful medical care is facially unconstitutional as it amounts to no medical care at all.

Pursuant to Texas law, and by his own admission, Sheriff Callahan is the keeper of the Wichita County Jail and is charged with safely keeping all persons committed to the Jail. (USCA5, Vol. 11, Jt. App. 346-348; 550-558). Texas law also provides that Sheriff Callahan exercises supervision and control over the Jail. TEX. LOC. GOV'T CODE ANN. Sec. 351.021(a). Sheriff Callahan was the official to whom the County Commissioners had delegated policy making authority. Dr. Bolin was also an official of County that had been designated policy making authority. Through their combined efforts, they had actual knowledge that the LVN's were not adequately trained to provide the type of care that inmates in the County's Jail needed. The County does not have any registered nurses and even Dr. Bolin testified that if he is not called or at the Jail that he is not the LVNs' supervisor. (USCA5, Vol. 11, Jt. App. 318-320). Sheriff Callahan testified that he does not supervise the nurses in their medical capacity. (USCA5, Vol. 11, Jt. App. 355-358). Accordingly, there are vast periods of time at the Jail when LVN's are being unsupervised in violation of the Texas Nurse Practices Act. (USCA5, Vol. 11, Jt. App. 419-429; 430-433; 550-558). Sheriff Callahan has not come forth with a single shred of evidence that would suggest that the unofficial policy of the Jail in providing care for inmates was not unlawful and exceeded the scope of the Texas Nurse Practices Act.

During this illegal period of unsupervised and unlawful practice of medicine, Decedent became the unfortunate guest of the Wichita County Jail. During this time, the standing illegal order approved by Sheriff Callahan allowed an illegal prescription medication that did not treat his symptoms but rather "masks" them, to be administered. These illegal practices killed Decedent.

C. Petitioners raised sufficient summary judgment evidence to overcome Sheriff Callahan's affirmative defense of qualified immunity based on Petitioners' allegation that Sheriff Callahan adopted jail policies or procedures with deliberate indifference.

The District Court correctly found that Petitioners produced evidence raising a genuine issue of material fact regarding whether (1) Dr. Bolin engaged in a widespread practice or custom of intimidating nurse and discouraging nurses from seeking emergency care for inmates with serious medical needs; (2) Sheriff Callahan was aware of and adopted or maintained the custom or policy of nurse intimidation; and (3) that the alleged policy or custom of nurse intimidation is itself a repudiation of constitutional rights and was the moving force of Decedent's death (USCA5, p. 3049-3050).

Dr. Bolin and Sherriff Callahan compounded the unconstitutional practice of requesting the Jail nurse staff to act outside their scope of authority by creating,

and/or condoning, significant barriers between Dr. Bolin and the nursing staff. Petitioners' summary judgment evidence clearly established that Dr. Bolin had a pattern and practice of harassing and intimidating the Jail nurse staff when they would call him for medical instruction that resulted in the Jail nurse staffs' reluctance to seek medical advice from Dr. Bolin. In his deposition, Dr. Bolin himself admitted to becoming irritated about receiving certain calls in the middle of the night from the Nursing Staff (USCA5, Vol. 10, Jt. App. 326). Dr. Bolin's demeanor and treatment of the Jail nursing staff was reported to Sheriff Callahan. Sheriff Callahan testified it was a standard complaint from the nurses that Dr. Bolin griped at them all the time and that when he is awakened in the night he is grumpy and does not like to be bothered (USCA5, Vol. 11, Jt. App. 374-376). Callahan further testified that he told the nurses to "ignore it" and told Dr. Bolin to "sweeten up". *Id.*

Petitioners have also come forward with affidavits from two former nurses at the Jail. Both Pathena Dawn Tweed ("Nurse Tweed") and Dawn Marie Wilkinson ("Nurse Wilkinson") have attested that on numerous occasions that when they would seek instruction from Dr. Bolin they would be chastised by Dr. Bolin and that they feared calling him for instruction.[1] (USCA5, Vol. 11, Jt. App. 559-562; 563-

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[1] Unlike the District Court, the Fifth Circuit refused to draw inferences in favor of Petitioners from the testimony of Nurse Tweed and Nurse Wilkinson. Apparently, the Fifth Circuit felt that the fact that both nurses decided to override Dr. Bolin's instruction to not take seriously ill inmates to the hospital negated their fear of Dr. Bolin. However, such a conclusion does not mean that all nurses would take seriously ill inmates to the hospital for

566). Nurse Tweed and Nurse Wilkinson further attested that they personally witnessed other nurses who were afraid to call Dr. Bolin for instruction and that they both personally complained about the situation to Nurse Ingram and Sheriff Callahan and that the response was basically to ignore it because that was "just the way Dr. Bolin is".[2] *Id*

Based on the summary judgment evidence, Petitioners clearly created fact issue as to whether Dr. Bolin's demeanor with his nurses resulted in the nurses being apprehensive about calling him in the middle of the night for supervision and guidance with medical care. Moreover, Petitioners clearly presented sufficient summary judgment evidence that Sheriff Callahan himself knew of the problems between the Jail nurse staff and Dr. Bolin but failed to take any real action to alleviate it. Finally, there is sufficient evidence to go to a jury that it was this custom that contributed to Decedent's death because as the records reflect, Nurse Krajca was conscious of an "ass-chewing" from Dr. Bolin in connection with her providing care to Decedent. (USCA5, Vol. 10, Jt. App. 162-163).

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fear of reprisal---in this case the inference should be made that Krajca did fear an "ass chewing."

[2] It is readily apparent that Sheriff Callahan's instruction to the nurses to just ignore Bolin's demeanor is still difficult for some of the nurses. Specifically, the director of nursing, Rose Ingram testified in connection in this case that she had never heard of any issues with Dr. Bolin and his treatment of the nurses. Apparently, Nurse Ingram cannot even ignore the reality of Dr. Bolin's demeanor even when the issue is exposed in a setting such as this lawsuit. (USCA5, Vol. 11, Jt. App. 387-388)

As set forth above, the various inmates' health care, including Decedent's, were entirely the responsibility of the Sheriff Callahan. Sheriff Callahan knew that a friction existed between Dr. Bolin and the Jail nurse staff and that the Jail nurse staff were afraid to call Dr. Bolin for medical instruction for fear of being chastised and berated. However, Sheriff Callahan did nothing meaningful to stop the intimidation. This fear and intimidation proximately caused the untimely death of Decedent. Accordingly, the District Court was correct in denying Sheriff Callahan's summary judgment based upon qualified immunity because a fact issue exits whether Sheriff Callahan turned a blind-eye to the volatile situation between the nurses and Dr. Bolin, which resulted in Decedent's death.

CONCLUSION

For the above and foregoing reasons, Petitioners respectfully request the issuance of a writ of certiorari to the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

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(any footnotes trail end of each document)

No. 09-10843

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

JANIS L. BROWN, Individually, and as Personal Representative of the Estate of Jason Ray Brown, Deceased; BILLY RAY BROWN, Plaintiffs - Appellees

v.

THOMAS J. CALLAHAN, Sheriff of Wichita County, Texas, in his Individual and Official Capacity, Defendant - Appellant

October 7, 2010, Filed

COUNSEL: For JANIS L. BROWN, Individually, and as Personal Representative of the Estate of Jason Ray Brown, Deceased, BILLY RAY BROWN, Plaintiffs - Appellees: Guy Hubert Riddle, Esq., Geffrey William Anderson, Anderson, Riddle & Kuehler, L.L.P., Fort Worth, TX.

For THOMAS J CALLAHAN, Sheriff of Wichita County, Texas, in his Individual and Official Capacity, Defendant - Appellant: Robert Scott Davis, Esq., David Ryan Herring Iglesias, Flowers Davis, P.L.L.C., Tyler, TX.

Before JONES, Chief Judge, PRADO, Circuit Judge, and OZERDEN, District Judge. *

EDITH H. JONES, Chief Judge:

Jason Brown died tragically while detained in the Wichita County Jail. His estate sued Sheriff Thomas Callahan for failure to train and supervise the jail's medical employees and for maintaining an unconstitutional policy of deliberate indifference to detainees' serious medical needs. The district court denied Sheriff Callahan's motion for summary judgment based on qualified immunity, and he appeals. Because there is insufficient evidence of deliberate indifference or objective unreasonableness by the Sheriff, we reverse.

I. BACKGROUND

The underlying facts are not in dispute. Jason Brown died of a gastrointestinal hemorrhage while in pretrial custody in the Wichita County Jail. During the 55 hours between Brown's book-in and his death, he informed the intake nurse of multiple serious medical problems, repeatedly vomited what appeared to be blood, complained of feeling unwell, requested to be sent to the emergency room, and ultimately was non-responsive for extended periods of time. During his confinement, Brown lacked access to his prescription medications. An attending jail nurse, Nurse Krajca, treated Brown's symptoms by giving him liquid antacid, placing him in a medical solitary cell, and administering an anti-nausea suppository. Brown was neither transferred to a hospital ER, nor was he seen by the jail's supervising physician, Dr. Bolin. In fact, no one from the jail ever contacted Dr. Bolin for his advice on Jason Brown. The jail's deputies, however, periodically checked Brown's condition from outside the medical solitary cell. When the deputies checked on him the next evening, Brown was dead.

Brown's parents, Janis and Billy Ray Brown, filed suit individually and as representatives of the estate of Jason Brown against Sheriff Callahan and others. Relevant to this appeal, the Appellees contend that Sheriff Callahan is liable for Brown's death in his individual capacity under 42 U.S.C. § 1983 under two possible theories. First, they argue that Callahan is personally responsible for training staff and supervising the medical treatment of individuals in the custody of the jail. More specifically, the Appellees allege that Sheriff Callahan failed to supervise properly the jail staff and Dr. Bolin, who intimidated the nurses, discouraging them from contacting the doctor or referring patients to the ER for further medical treatment. Second, the Browns allege that the Sheriff ratified as custom or policy Dr. Bolin's intimidation of the nursing staff that caused their son's death.

Sheriff Callahan moved for summary judgment, asserting qualified immunity. The district court denied his motion. It found that the Appellees offered sufficient evidence to create material fact issues whether (a) Sheriff Callahan failed adequately to supervise the jail's medical personnel, and (b) approved or ratified "Defendant Bolin's pattern and practice of harassing and intimidating jail nurses when they would call him with questions regarding nursing care, discouraging sending inmates to the hospital causing Brown's death." The same evidence persuaded the court that Sheriff Callahan's actions may have been objectively unreasonable and therefore not protected by qualified immunity. Sheriff Callahan appeals.

II. STANDARD OF REVIEW

This court reviews a denial of a public official's motion for summary judgment on the issue of qualified immunity by determining "whether the district court erred in assessing the legal significance of the conduct that the district court deemed sufficiently supported for purposes of summary judgment." *Kinney v. Weaver*, 367 F.3d 337, 347 (5th Cir. 2004) (en banc). The court reviews *de novo* the district court's legal determination of the materiality of the identified fact issues. *Lemoine v. New Horizons Ranch & Ctr., Inc.*, 174 F.3d 629, 634 (5th Cir. 1999). Summary judgment is required if the movant establishes that there are no genuine issues of material fact and the movant is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c).

A qualified immunity defense alters the usual summary judgment burden of proof. *See Michalik v. Hermann*, 422 F.3d 252, 262 (5th Cir. 2005). Once an official pleads the defense, the burden then shifts to the plaintiff, who must rebut the defense by establishing a genuine fact issue as to whether the official's allegedly wrongful conduct violated clearly established law. *Id.* The plaintiff bears the burden of negating qualified immunity, *id.*, but all inferences are drawn in his favor.

The qualified immunity defense has two prongs: whether an official's conduct violated a constitutional right of the plaintiff; and whether the right was clearly established at the time of the violation. *Manis v. Lawson*, 585 F.3d 839, 843 (5th Cir. 2009). A court may rely on either prong of the defense in its analysis. *Id.*

If the defendant's actions violated a clearly established constitutional right, the court then asks whether qualified immunity is still appropriate because the

defendant's actions were "objectively reasonable" in light of "law which was clearly established at the time of the disputed action." *Collins v. Ainsworth*, 382 F.3d 529, 537 (5th Cir. 2004) (citations omitted). Whether an official's conduct was objectively reasonable is a question of law for the court, not a matter of fact for the jury. *Williams v. Bramer*, 180 F.3d 699, 703 (5th Cir. 1999). To be clearly established for purposes of qualified immunity, the contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right. *Brown v. Miller*, 519 F.3d 231, 236 (5th Cir. 2008). The unlawfulness of the defendant's actions must have been readily apparent from sufficiently similar situations, but it is not necessary that the defendant's exact act have been illegal. *Id.* at 236-37. An official's actions must be judged in light of the circumstances that confronted him, without the benefit of hindsight. *Graham v. Connor*, 490 U.S. 386, 396-97, 109 S. Ct. 1865, 104 L. Ed. 2d 443 (1989). In essence, a plaintiff must allege facts sufficient to demonstrate that no reasonable officer could have believed his actions were proper. *Babb v. Dorman*, 33 F.3d 472, 477 (5th Cir. 1994).

III. DISCUSSION

As a pretrial detainee, Jason Brown had a clearly established Fourteenth Amendment right not to be denied, by deliberate indifference, attention to his serious medical needs. *Hare v. City of Corinth*, 74 F.3d 633, 650 (5th Cir. 1996) (en banc). Whether Dr. Bolin, jail nurses, or other staff violated Brown's rights is not before us; the Browns' case against Dr. Bolin and Nurse Kracja, awaits trial pending the outcome of this appeal, and we express no opinion on its merits. Sheriff

Callahan had no knowledge of and did not participate in the events surrounding Brown's fatal period of detention. Thus, the Sheriff can only be held liable in his capacity as a supervisor of the jail for his own unconstitutional conduct. *City of Canton v. Harris*, 489 U.S. 378, 385, 109 S. Ct. 1197, 103 L. Ed. 2d 412 (1978) (no respondeat superior liability of supervisors).

The Browns have alleged two theories of supervisory liability, which, being founded on the same facts, may be discussed together. Mirroring the requirements in this circuit, they contend first that Callahan failed to train or supervise Dr. Bolin and the jail staff; that a causal link exists between the failure to train or supervise and the unconstitutional denial of medical care to Jason; and his failure to train or supervise amounts to deliberate indifference. *Estate of Davis v. City of N. Richland Hills*, 406 F.3d 375, 381-82 (5th Cir. 2005).[1] Their second theory of liability is that the Sheriff ratified or condoned Dr. Bolin's custom or policy of intimidating nurses from providing needed medical care, and the custom or policy was "so deficient that the policy itself is a repudiation of constitutional rights and is the moving force of the constitutional violation." *Cozzo v. Tangipahoa Parish*, 279 F.3d 273, 289 (5th Cir. 2002) (citing *Thompkins v. Belt*, 828 F.2d 298, 304 (5th Cir. 1987).

For purposes of analysis, we assume *arguendo* that Jason Brown experienced an unconstitutional denial of medical care while a pretrial detainee, and that the denial of care enabled his gastrointestinal hemorrhage to become fatal.

The facts relevant to the Browns' theories, developed in discovery, demonstrate that the Sheriff is legally responsible for operating the county jail. TEX. LOC. GOVT. CODE ANN. § 351.041(a). In the mid 1990's the County executed a contract with Dr. Bolin explicitly requiring the doctor to supervise the professional work of the jail's medical staff, six Licensed Vocational Nurses (LVNs), while the Sheriff supervised their employment. During the period in question, the jail's formal medical care plan complied with state standards. The Browns have offered no evidence that any detainee before Jason Brown experienced allegedly substandard medical care or any denial of his constitutional right to receive medical care at the Wichita County jail.

Viewed in the light most favorable to the Browns, however, there was conflicting testimony from Callahan, Dr. Bolin, and present and former nurses concerning the extent and quality of Callahan's supervision of Dr. Bolin and the nurses. Two former jail nurses attested to two incidents in which each consulted Dr. Bolin about an inmate's medical condition and was instructed not to send the patient to the emergency room for treatment. The nurses did so anyway. Their affidavits state that Dr. Bolin was rude to nurses and intimidated them, and he disliked being called for advice at nighttime. Each nurse complained to the Sheriff about the two specific confrontations with Dr. Bolin over sending a patient to the ER. These nurses also claim to have witnessed Dr. Bolin's mistreatment of other nurses on the jail staff. Additionally, Nurse Kracja, who oversaw Jason Brown's treatment, expressed reluctance to send Brown to the ER because she did not want an "ass-chewing" from the doctor.[2]

Sheriff Callahan did not deny that he was aware of Dr. Bolin's unpleasant behavior during a ten-year stint as the jail's contract physician. He admitted that Bolin "gripes all the time" at employees. The Sheriff's response was two-fold. He testified that he advised the doctor on several occasions to "sweeten up" toward the nurses. The Sheriff also instructed the nurses to continue calling the doctor at any time, irrespective of Dr. Bolin's grumpiness, if they felt it appropriate.[3]

These last two paragraphs summarize the evidence found sufficient by the district court to raise genuine and material fact issues not only on each prong of the Browns' theories of unconstitutional supervision and an unconstitutional policy, but also on whether Callahan's conduct was so objectively unreasonable, *i.e.* plainly incompetent or a knowing violation of law, that a jury could deny him qualified immunity. Despite our sympathy for Jason's plight and our respect for the district court's conscientious effort, we must disagree. Even if we assume *arguendo* that the sheriff's supervision of Dr. Bolin or the nursing staff was inadequate and that there was a causal link between his failure and Brown's death, we cannot conclude that there is a genuine material fact issue as to Callahan's deliberate indifference to constitutional rights. Evidence is also lacking to prove the objective unreasonableness, for immunity purposes, of Sheriff Callahan's management of the jail's medical care.

Deliberate indifference is "a stringent standard of fault, requiring proof that a municipal actor disregarded a known or obvious consequence of his action." *Bd. of Cnty. Comm'rs of Bryan Cnty. v. Brown*, 520 U.S. 397, 410, 117 S. Ct. 1382, 137 L. Ed. 2d 626 (1997). Deliberate

indifference implies an official's actual knowledge of facts showing that a risk of serious harm exists as well as the official's having actually drawn that inference. *Smith v. Brenoettsy*, 158 F.3d 908, 912 (5th Cir. 1998) (internal quotation marks and citations omitted). Deliberate indifference is more than mere negligence or even gross negligence. *City of Canton*, 489 U.S. at 388. Proof of deliberate indifference normally requires a plaintiff to show a pattern of violations and that the inadequate training or supervision is "obvious and obviously likely to result in a constitutional violation." *Estate of Davis*, 406 F.3d at 381 (citations omitted).

Here, evidence of Sheriff Callahan's failure to supervise Dr. Bolin and the nursing staff is simply too attenuated to permit the inference that the Sheriff was deliberately indifferent, *i.e.*, that he ignored a known or obvious risk of unconstitutionally deficient medical care. The complaints are that he condoned or ratified Dr. Bolin's harassing and intimidation of the nursing staff, failed to supervise Dr. Bolin's actions that discouraged the nurses from calling the doctor or sending patients to the ER, and failed to supervise the nurses to work with Dr. Bolin for the inmates' best care. A jury would be asked to infer from Dr. Bolin's unpleasant attitude not only that the nurses would be unhappy but that they would be so intimidated as not to respond to the inmates' serious medical needs.

Yet apart from Nurse Kracja's expressed fear of an "ass-chewing," there is no allegation of unconstitutionally deficient medical care attributable to fear of Dr. Bolin's response before Jason Brown died. That two nurses decided to send inmates to the ER over Dr. Bolin's objections proves the opposite of

intimidation. The Appellees do not even allege that nurses had been disciplined or terminated in the past for seeking Dr. Bolin's assistance. A doctor's bad temper is nothing for his employing organization to be proud of, but standing alone, it does not create a known or obvious risk of inadequate medical care. Further, the fact that the nurses and Dr. Bolin disagreed in two instances on whether particular inmates should be sent to the ER does not, without more proof, raise an inference that those other inmates were subjected to constitutionally inadequate care. Appellees do not allege that Dr. Bolin refused to consult with nurses when presented with symptoms resembling those of Brown, or when any detainee exhibited other similarly severe symptoms like vomiting blood. They do not allege that nurses had tried in the past to refer similarly ailing inmates to the ER but were denied, either because of Dr. Bolin or otherwise.

The Browns, in sum, fail to establish a factual connection between Dr. Bolin's demeanor and any actual adverse consequences to the nursing staff or any prior instance in which the quality of the inmates' medical care was diminished because of Dr. Bolin's communication problems with them. In light of these deficiencies, the risk arising from Dr. Bolin's behavior was not clearly related to constitutionally inadequate medical care. No reasonable jury could find that Sheriff Callahan knew of, much less disregarded or ignored an obvious risk. Indeed, he counseled Dr. Bolin and ordered the nurses to act appropriately notwithstanding Bolin's distemper, and the Browns have shown no prior instance in which the Sheriff's instruction to the nurses was not followed.[4] The ultimate question is not whether a jury, in hindsight,

could conclude that the Sheriff could have engaged in better supervision of the jail's medical care but whether his supervision was so utterly heedless as to amount to deliberate indifference. That stringent test is not met here.

The district court also held that a fact issue exists as to whether Sheriff Callahan condoned or ratified a "policy" of nurse intimidation carried out by Dr. Bolin that discouraged nurses from seeking emergency care for inmates with serious medical needs. It is unlikely such a policy can be legitimately inferred from the scant evidence above without disserving the principle that a "policy" must be "persistent," "widespread," "common" and "well settled." *See Cozza*, 279 F.3d at 289. Dr. Bolin's "policy" may have been to mistreat the staff, but whether the policy's effect was to discourage inmates from receiving adequate medical care is barely substantiated. Nonetheless, the Sheriff's potential liability for an unconstitutional policy runs afoul of the second prong of qualified immunity analysis, where the dispositive inquiry is "whether it would be clear to a reasonable officer that his conduct was unlawful in the situation he confronted." *Saucier v. Katz*, 533 U.S. 194, 202, 121 S. Ct. 2151, 150 L. Ed. 2d 272 (2001). This court has interpreted "clearly established law" on the subject of policy promulgation to require "an intentional choice" and amount to subjective deliberate indifference. *Rhyne v. Henderson Cnty.*, 973 F.2d 386, 392 (5th Cir. 1992). It must be "obvious that the likely consequences of not adopting a policy will be a deprivation of civil rights." *Id.*, quoted in *Brumfield v. Hollins*, 551 F.3d 322, 328 (5th Cir. 2008). Applied to this case, it would have had to be clear to the Sheriff that condoning or ratifying Dr. Bolin's practice of nurse intimidation

would in fact discourage nurses from seeking constitutionally adequate medical care for the detainees. That he did not have the subjective knowledge required for deliberate indifference and imputation of liability has been explained above.

There is also insufficient evidence from which a reasonable jury could infer that Callahan's conduct did not deserve qualified immunity. The district court relied on the same evidence related above that shows, at worst, the Sheriff's negligent supervision of Dr. Bolin and the doctor's relationship with the nursing staff. In the absence of any prior incidents that connoted inadequate medical care at the jail, it is impossible to infer that the Sheriff was essentially callous about inmate medical care or had any reason to suspect the level of care had become or could become constitutionally inadequate. The Sheriff was neither plainly incompetent nor knowingly violating the law, nor were his actions, in the circumstances he faced, objectively unreasonable. He took some steps to curtail Dr. Bolin's intimidation and require the nurses to call the doctor as necessary. A "pattern" of verbal nurse intimidation and harassment cannot alone place a supervisor on notice that inmates are receiving medical care so deficient as to violate the Constitution.

CONCLUSION

Jason Brown's tragic, lonely death deserved investigation and a careful review of the Wichita County Jail's practices toward visibly ill inmates. Neither the demanding test for supervisory § 1983 liability, however, nor the test for official qualified immunity has been factually demonstrated against

Sheriff Callahan simply because he knew the jail doctor mistreated the nursing staff.

REVERSED.

Footnotes

*District Judge of the Southern District of Mississippi, sitting by designation.

1A supervisor may be held liable under § 1983 for failure to train or supervise subordinates if (1) the supervisor failed to train or supervise; (2) a causal link exists between the failure and violation of plaintiff's rights; and (3) the failure to train or supervise amounts to deliberate indifference. *Estate of Davis*, 406 F.3d at 381.

2Specifically, Nurse Kracja told Detention Officer Sours during a cigarette break (after she had ordered Brown transferred to a medical solitary cell): "[d]o you know what kind of ass-chewing I would get from Dr. Bolin if I sent [Brown] to the hospital in the good health that he is in?" We interpret this ambiguous remark in the light most favorable to the Browns.

3In their briefing, the Browns emphasize a contention that the nurses were asked to perform medical duties, *e.g.* assessment and treatment of patients and administration of medication, beyond their training as LVNs. The district court cited a lack of evidence of any specific training deficiencies although the court viewed this contention as also related to a failure to supervise the nurses. Even if, as a hypothetical matter, LVNs were insufficiently trained for the duties they actually

performed at the Wichita County Jail, nothing about the history of jail medical operations made it "obviously likely that a constitutional violation of this sort would result." The record does not show past incidents when a detainee died or suffered grievous harm because nursing staff failed to properly assess the severity of the detainee's symptoms. The record does not show instances where LVNs were obviously inadequately trained, leading to gross misdiagnoses or harms resulting from the prescription and administration of improper drugs. In these circumstances, the district court properly focused on the failure to supervise theory rather than failure to train.

4The Browns do not contend, nor is there a basis for finding, that the treatment accorded Jason falls within the "single incident" exception to the usual requirement that to prove deliberate indifference, a supervisor must be on notice of a pattern of similar unconstitutional behavior. *Estate of Davis*, 406 F.3d at 382, 383.

8/4/2009

CIVIL ACTION NO. 7:05-CV-0108-O-KA

WICHITA COUNTY, TEXAS,

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

JANIS L. BROWN, Individually and as Personal Representative of the Estate of JASON RAY BROWN, Deceased, and BILLY RAY BROWN,
Plaintiffs,

VS.

THOMAS J. CALLAHAN, Sheriff of Wichita County, Texas, in his Individual and Official Capacity, DANIEL H. BOLIN, M.D., in his Individual and Official Capacity, KAYE KRAJCA, in her Individual and Official Capacity, MICHELLE GEORGE, in her Individual and Official Capacity, ROSE INGRAM, in her Individual and Official Capacity, DICKEY LEE SOURS, JR., in his Individual and Official Capacity, BLAINE GREENE, in his Individual and Official Capacity, WILLIAM YEAGER, in his Individual and Official Capacity, GARY WHATLEY, in his Individual and Official Capacity, JAMES GEARY, in his Individual and Official Capacity, WESLEY DICKERMAN, in his Individual and Official Capacity, and WAYNE PARISH, in his Individual and Official Capacity,
Defendants.

MEMORANDUM OPINION AND ORDER

Before the Court are the following:

1. Defendant Thomas J. Callahan's Motion for Summary Judgment (Doc. # 126);
2. Plaintiffs' Response to Callahan's Motion for Summary Judgment (Doc. # 127);
3. Plaintiffs' Brief in Support of their Response (Doc. # 127);
4. Defendant Thomas J. Callahan's Reply (Doc. # 128);
5. The parties' Joint Appendix (Doc. # 129);
6. Defendant Thomas J. Callahan's Response to Plaintiffs' Objections to Evidence (Doc. # 130); and
7. Defendant Thomas J. Callahan's Ojections to Plaintiffs' Summary Judgment Evidence (Doc. # 131).

Having reviewed the relevant briefing, evidence, and applicable law, the Court finds as follows:

I. Background

Plaintiffs are the relatives and personal representative of the Estate of Jason Brown ("Brown"). Doc. # 1 (Compl.). Plaintiffs bring claims against Wichita County, jail physician Dr. Bolin, Wichita County Sheriff Thomas Callahan, jail nurses, and jail detention officers arising out of Brown's death at a Wichita County jail facility. Doc. # 86 (Amd. Compl.).

Jason Brown was arrested on a drug charge and brought to the Wichita County jail on July 22, 2004. Jt. App. at 203. En route to the jail, Brown began crying and pleaded with the arresting officer to release him because he had medical problems and did not have long to live.

Id. at 208. The arresting officer advised the jail staff upon arrival at the jail of Brown's medical problems. *Id.*

After intake procedures were completed, Brown was put in the general inmate population. *Id.*

Around 11:42 p.m. on July 23, 2004, someone in the general population tank pushed the emergency button and notified the control room that an inmate had thrown up blood. *Id.* at 94. Detention officers Dickey Lee Sours, Jr. and Blaine Greene responded to the call. *Id.* at 207-08. Detention officer Sours reported that he found Brown laying on his side next to a puddle of blood 1 to 1.5 feet in width and 2 to 2.5 feet in length, with chunks of food in the puddle. *Id.* At 162. Detention officer Greene reported that the officers saw a big puddle of blood. *Id.* at 170. Nurse Krajca was called and told of the situation, and over the phone, Krajca asked the detention officers to give Brown some liquid antacids. *Id.* at 162.

Later, Brown complained that he was in pain and begged for help. *Id.* Krajca was again called, and asked "did anyone actually see him (Brown) throw up the blood?" *Id.* Sours responded, "Kaye (Krajca), I had to clean it up." *Id.* Krajca advised that Brown should be given suppositories, but Brown would not take them. *Id.* Krajca was called again and told that Brown was not coherent. *Id.* Krajca then went to the jail to visit Brown. *Id.*

There is a dispute in the evidence regarding what happened next. There is evidence suggesting that Brown told Nurse Krajca he had nausea and vomiting, and also informed her that he had several medical problems including auto immune chronic hepatitis A, B, and C, esophageal varies, jaundice, spleenial magaly, and anemia. *Id.* at 184, 205. However, there is also

evidence indicating that Nurse Krajca could not get Brown to respond. *Id.* at 162.

There is no dispute that Krajca then had Brown moved to medical solitary, and gave Brown suppositories. *Id.* at 162, 183, 205. Later, during a cigarette break, Nurse Krajca asked Sours "[d]o you know what kind of ass chewing I would get from Dr. Bolin if I sent him (Brown) to the hospital in the good health that he is in?" *Id.* at 162, 208.

On Saturday, July 24, 2004, between 3:12 a.m. and 11:30 p.m., detention officers allegedly monitored Brown through a slot in the cell door. At approximately 11:30 p.m., Brown was found unresponsive and pulseless by the two officers. *Id.* at 183, 184, 190, 203. Nurse Krajca advised the officers to call emergency services. *Id.* at 183. The medical response team reported that Brown had expired quite some time prior to arrival. *Id.* at 201. The autopsy report indicates that Jason Brown died from a massive gastrointestinal hemorrhage at the age of 26. *Id.* at 222.

Plaintiffs filed suit on June 8, 2005, bringing claims against jail nurses, detention officers, the jail physician, Wichita County, and Wichita County Sheriff Thomas Callahan. Compl. Plaintiffs allege that Defendant Callahan violated Plaintiffs' rights under the Fourteenth Amendment by adopting and/or condoning unconstitutional policies and by failing to train and supervise jail staff, causing Brown's death. Amd. Compl.

On February 29, 2009, Defendant Callahan filed his motion for summary judgment as to Plaintiffs' claims

asserted against him in his individual capacity. Callahan argues that Plaintiffs have no evidence demonstrating that Callahan violated constitutional rights and that he is entitled to qualified immunity. Plaintiffs respond that Defendant Callahan's motion for summary judgment has failed to address the claims that have been levied against him, and that Plaintiffs have produced ample summary judgment evidence.

The issues have been briefed and this matter is ripe for determination.

II. Legal Standard

Summary judgment is proper when the pleadings and evidence on file show that no genuine issue exists as to any material fact and that the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c). "[T]he substantive law will identify which facts are material." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A genuine issue of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the non-moving party." *Id.* The movant makes a showing that there is no genuine issue of material fact by informing the court of the basis of its motion and by identifying the portions of the record which reveal there are no genuine material fact issues. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986); FED. R. CIV. P. 56(c).

Once the movant makes this showing, the non-movant must then direct the court's attention to evidence in the record sufficient to establish that there is a genuine issue of material fact for trial. *Celotex*, 477 U.S. at 323-24. To carry this burden, the "opponent must do more

than simply show. . . some metaphysical doubt as to the material facts." *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). Instead, the non-movant must show that the evidence is sufficient to support a resolution of the factual issue in his favor. *Anderson*, 477 U.S. at 249. Neither conclusory allegations nor unsubstantiated assertions will satisfy the non-movant's summary judgment burden. *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075 (5th Cir. 1994) (en banc); *Topalian v. Ehrman*, 954 F.2d 1125, 1131 (5th Cir. 1992). The party opposing summary judgment is required to identify specific evidence in the record and to articulate the precise manner in which that evidence supports his claim. *Ragas v. Tenn. Gas Pipeline Co.*, 136 F.3d 455, 458 (5th Cir. 1998). Summary judgment in favor of the defendant is proper if, after adequate time for discovery, the plaintiff fails to establish the existence of an element essential to his case and to which he will bear the burden of proof at trial. *Celotex*, 477 U.S. at 322-23.

When weighing the evidence on a motion for summary judgment, the Court must decide all reasonable doubts and inferences in the light most favorable to the non-movant. *See Walker v. Sears, Roebuck & Co.*, 853 F.2d 355, 358 (5th Cir. 1988). The Court cannot make a credibility determination in light of conflicting evidence or competing inferences. *Anderson*, 477 U.S. at 255. As long as there appears to be some support for the disputed allegations such that "reasonable minds could differ as to the import of the evidence," the motion for summary judgment must be denied. *Id.* at 250.

III. Analysis

Defendant Callahan moves for summary judgment on Plaintiffs' clai ıs for violations of the Fourth and Fourteenth Amendments, brought pursuant to 42. U.S.C. § 1983, asserted against Callahan in his individual capacity. To state a claim under 42 U.S.C. § 1983, a plaintiff must demonstrate: (1) a violation of the United States Constitution or of federal law; and (2) that the violation was committed by someone acting under color of state law. *See Attenberry v. Nocona Gen. Hosp.*, 430 F.3d 245, 252-53 (5th Cir. 2005). In this case, Plaintiffs' claim that Defendant Callahan, sheriff of Wichita County, violated Plaintiffs' Fourth and Fourteenth Amendment rights by denying Brown adequate medical care. Defendant Callahan argues that Plaintiffs have failed to establish any constitutional violation and that, even assuming such a violation, he is entitled to qualified immunity.

The doctrine of qualified immunity protects government officials sued pursuant to § 1983 "from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." *Pearson v. Callahan*, ___U.S.___, 129 S.Ct. 808, 815 (2009) (citing *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982)). Qualified immunity balances two important interests - the need to hold public officials accountable when they exercise power irresponsibly and the need to shield officials from harassment, distraction, and liability when they perform their duties reasonably. *Id.* This doctrine protects "all but the plainly incompetent or those who knowingly violate the law." *Malley v. Briggs*, 475 U.S. 335, 341 (1986).

Courts generally apply the two-pronged analysis established in *Saucier v. Katz*, 533 U.S. 194 (2001), in determining whether a government official is entitled to qualified immunity for an alleged constitutional violation. The first prong of the *Saucier* analysis asks whether, taken in the light most favorable to plaintiff, the facts alleged show that the official's conduct violated a constitutional right. *See Scott v. Harris*, 550 U.S. 372 (2007) (citing *Saucier v. Katz*, 533 U.S. 194 (2001)). Under *Saucier*, if, and only if, the Court finds a violation of a constitutional right, the Court then asks whether the right was clearly established in light of the specific context of the case. *Id.* If there is evidence to support the violation of a constitutional right, the Court asks whether, nevertheless, qualified immunity is appropriate because defendant's actions were objectively reasonable "in light of clearly established law at the time of the conduct in question." *Hampton Co. Nat'l Sur., L.L.C. v. Tunica County, Miss.*, 543 F.3d 221, 225 (5th Cir. 2008).

The Supreme Court has recently clarified that it is no longer mandatory for courts to consider the two prongs set out in *Saucier* in order, although the Court noted that it may be beneficial to do so. *Pearson*, 129 S.Ct. at 815. Under *Pearson*, courts are now permitted to exercise their sound discretion in deciding which of the two prongs of the qualified immunity analysis should be addressed first in light of the circumstances in the particular case at hand. *Id.*

The usual summary judgment burden of proof is altered in the context of a defense of qualified immunity. *See Gates v. Texas Dep't of Protective and Regulatory Servs.*, 537 F.3d 404, 419 (5th Cir. 2008). An official need

only plead his or her good faith, which then shifts the burden to the plaintiff, who must rebut the defense by establishing that the official's allegedly wrongful conduct violated clearly established law. *See Michalik v. Hermann*, 422 F.3d 252, 262 (5th Cir. 2005) (citing *Bazan v. Hidalgo County*, 246 F.3d 481, 489 (5th Cir. 2001)). To negate a defense of qualified immunity and avoid summary judgment, the plaintiff need not present "absolute proof," but must offer more than "mere allegations." *Ontiveros v. City of Rosenburg, Tex.*, No. 08-20081, 2009 WL 807450 at *2 (5th Cir. Mar. 20, 2009).

Defendant Callahan pleaded the affirmative defense of qualified immunity. At the summary judgment stage, a determination of whether a constitutional right was violated overlaps substantially with the determination of whether the first prong of the qualified immunity analysis is satisfied. Accordingly, the Court first addresses whether Plaintiffs have raised a genuine issue of material fact that Defendant Callahan violated Brown's rights under the Fourth and Fourteenth Amendments, and then considers whether Defendants' actions were objectively unreasonable.

A. Plaintiffs' Fourth Amendment claims

Defendant Callahan moves for summary judgment on Plaintiffs' section 1983 claims under the Fourth Amendment. Callahan argues that since Brown was a pretrial detainee at the time of the alleged constitutional violation, the Fourth Amendment is inapplicable. In their response, Plaintiffs state that they agree the events leading up to the death of Brown do not support a claim for Fourth Amendment violations.

Accordingly, the Court finds that summary judgment is appropriate with respect to Plaintiffs' claims against Defendant Callahan for violation of the Fourth Amendment.

B. Plaintiffs' Fourteenth Amendment claims

Defendant Callahan also asserts that he is entitled to summary judgment with respect to Plaintiffs' section 1983 claims based on violation of the Fourteenth Amendment. Callahan notes that he was not aware that Brown was in the Wichita County jail, did not have any information regarding Brown, and could not have been deliberately indifferent to Brown.

The Fifth Circuit has recognized a pretrial detainee's Fourteenth Amendment right not to have his serious medical needs met with deliberate indifference by jail officials.[1] *Hare v. City of Cornith, Miss.*, 74 F.3d 633, 650 (5th Cir. 1996). A prison official acts with deliberate indifference only if the official (A) knows that the inmate faces a substantial risk of serious bodily harm and (B) disregards that risk by failing to take reasonable measures to abate it. *Gobert v. Caldwell*, 463 F.3d 339, 346 (5th Cir. 2006) (citing *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)). Mere negligence will not suffice, and deliberate indifference cannot be inferred from a failure to act reasonably. *See Hare*, 74 F.3d at 649-50. Unsuccessful medical treatment, acts of negligence, or medical malpractice do not constitute deliberate indifference, nor does a prisoner's disagreement with his medical treatment, absent exceptional circumstances. *Id.*; *Gobert*, 364 F.3d at 347; *Harris v. Hegmann*, 198 F.3d 153, 159 (5th Cir. 1999). Deliberate indifference requires a showing that officials

refused to treat the detainee, ignored his complaints, intentionally treated him incorrectly, or engaged in similar conduct that would clearly evince a wanton disregard for any serious medical needs. *Domino v. Tex. Dept. of Criminal Justice*, 239 F.3d 752, 756 (5th Cir. 2001).

The undisputed evidence shows that Defendant Callahan did not know inmate Brown and had no contact with Brown while he was at the Wichita County jail facilities. Accordingly, Plaintiffs have failed to establish Callahan is liable under § 1983 based on any direct interaction with, or knowledge of, inmate Brown.

Even though there is no evidence that Callahan interacted directly with or had knowledge of Brown during his incarceration, Callahan may still be held personally liable, under certain circumstances, for acts or omissions due to his role as supervisor at the Wichita County jail. Supervisory liability may exist without an official's overt personal participation in a direct offensive act where an official implements, adopts, or maintains a custom or policy that is so deficient that the policy itself is a repudiation of constitutional rights and is the moving force of a constitutional violation. *See Cozzo v. Tangipahoa Parish Council-President Gov't*, 279 F.3d 273, 289 (5th Cir. 2002). An official policy is:

1. A policy statement, ordinance, regulation, or decision that is officially adopted and promulgated by [the government entity] . . . or by an official to whom the [entity] ha[s] delegated policy-making authority; or

2. A persistent, widespread practice of . . . officials or employees, which , although not authorized by officially

adopted and promulgated policy, is so common and well settled as to constitute a custom that fairly represent [the entity's] policy.

Id. (citing *Johnson v. Moore*, 958 F.2d 92, 94 (5th Cir. 1992)). A plaintiff may also establish a custom or policy based on an isolated decision made in the context of a particular situation if the decision was made by an authorized policymaker in whom final authority rested regarding the action ordered. *Id.; City of St. Louis v. Praprotnik*, 485 U.S. 112, 124-25 (1988); *Bennett v. Pippin*, 74 F.3d 578, 586 (5th Cir. 1996).

A supervisor may also be held liable under § 1983 for failure to properly supervise and train subordinate officers who cause a deprivation of constitutional rights. *Wever v. LincolnCounty*, 388 F.3d 601, 606-607 (8th Cir. 2004). The plaintiff must show that (1) the supervisor either failed to supervise or train the subordinate official; (2) a causal link exists between the failure to train or supervise and the violation of plaintiff's rights; and (3) the failure to train or supervise amounts to deliberate indifference. *Id.* at 911-12 (citing *Hinshaw v. Doffer*, 785 F.2d 1260, 1263 (5th Cir. 1986)). "[T]he misconduct of the subordinate must be affirmatively linked to the action or inaction of the supervisor." *Southard v. Tex. Bd. Of Criminal Justice*, 114 F.3d 539, 550 (5th Cir. 1997). Only the direct act or omission of the supervisory official will give rise to individual liability under § 1983; a supervisor may not be held individually liable under a theory of *respondeat superior. Coleman v. Houston Indep. Sch. Dist.*, 113 F.3d 528, 534 (5th Cir. 1997).

Plaintiffs argue that they have produced evidence that Callahan implemented and/or condoned unconstitutional policies and failed to train and supervise subordinates at the jail, causing Brown's death. Amd. Compl. Defendant Callahan argues that Plaintiffs have failed to produce any evidence in support of these allegations, and notes that jail staff receive the appropriate level of state-mandated training, precluding liability for failure to train.

The Court now considers whether Plaintiffs have raised a genuine issue of material fact regarding whether Callahan implemented or adopted an unconstitutional policy.

1. Policy or Custom

Plaintiffs allege that Defendant Callahan ratified Defendant Bolin's pattern and practice of harassing and intimidating jail nurses when they would call him with questions regarding nursing care, discouraging sending sick inmates to the hospital, causing Brown's death. In support of this assertion, Plaintiffs offer evidence including affidavits from two former jail nurses, the testimony of Defendant Callahan, and evidence suggesting that Nurse Krajca believed she would have been reprimanded for sending Jason Brown to the hospital.

a. Affidavits of Former Jail Nurses

Plaintiffs have submitted affidavits from former jail nurses Pathena Dawn Tweed and Dawn Marie Wilkinson.[2] *Id.* at 559-62. Both nurses averred that they have personally observed Dr. Bolin berate jail nurses

who called him for medical instruction or direction, and that Dr. Bolin's demeanor intimidated the nurses working under him. *Id.* Both nurses further avered that they personally feared calling Bolin for fear of unwarranted criticism. *Id.*

Ms. Tweed and Ms. Wilkinson further averred that they perceived that Dr. Bolin did not want inmates being sent to the emergency room because it would be Dr. Bolin's responsibility to then go to the hospital to provide care for the inmate. Wilkinson stated that she personally experienced this when a female inmate complained of abdominal pains, and reported that she had been raped prior to being arrested and detained. Wilkinson stated that she inspected the inmate, and discovered that the inmate had a tampon lodged deep into her body that neither she nor the inmate could remove. Wilkinson further averred that she recognized the situation required immediate medical attention, so she called Dr. Bolin for medical instruction, but was advised not to send the inmate to the emergency room and to remove the tampon herself. Wilkinson stated that she disobeyed Dr. Bolin's instruction, calling an ambulance and driving her own vehicle to the hospital to be with the inmate. *Id.*

Ms. Tweed averred to a similar situation involving an inmate with very low blood sugar. Tweed stated that she called Dr. Bolin for instruction regarding the inmate and that Dr. Bolin informed her not to send the inmate to the emergency room "under any circumstances," advising Ms. Tweed to take whatever other action she believed necessary to bring the inmates blood sugar levels up. Tweed stated that after several failed attempts to raise the inmate's blood

sugar level, she had the inmate transported to the hospital for emergency treatment. Tweed stated that, upon learning of her decision to send the inmate to the emergency room, Dr. Bolin became very irate, yelled at Ms. Tweed, and questioned why she had defied his orders. *Id.*

Ms. Tweed and Ms. Wilkinson both averred that they spoke with Sheriff Callahan about Dr. Bolin's treatment of them and other nurses, but that they were advised something to the effect that "this is just the way he (Bolin) is" and were instructed to ignore Bolin's behavior. *Id.*

b. Callahan's Testimony

Plaintiffs have produced Defendant Callahan's deposition testimony, including testimony in which he acknowledges that he received complaints regarding Bolin's treatment of employees at the jail. Specifically, Callahan testified that he heard that Bolin gripes all the time at employees, including the nurses. *Id.* at 374. Callahan stated that he had been told that Bolin is grumpy when he is awakened in the middle of the night, and that Bolin doesn't like to be bothered. *Id.* at 374-75. Callahan testified that this is a common reputation that Bolin has among nurses. *Id.* at 375. Callahan further testified that nurses were told to ignore this, and to call Bolin any time that they need to. *Id.* Callahan stated that he has spoken with Bolin about this two or three times over the past ten to twelve years, and that Callahan told Bolin to "sweeten up" and "get a little nicer." *Id.* at 375-76.

c. Evidence regarding Brown's death

Plaintiffs have produced evidence suggesting that Nurse Krajca violated Plaintiffs' constitutional rights by denying Brown adequate medical treatment. *See* Doc. # 153, Memorandum Opinion and Order resolving Krajca's motion for summary judgment, entered May 20, 2008. The Court has found that disputed evidence suggests that Nurse Krajca was aware that Brown had serious medical conditions including hepatitis A, B, and C, esophageal varices, jaundice, spleenial magaly, and anemia; that Brown regurgitated blood and was complaining of gastric ulcers; and that Brown was incoherent and unresponsive; but that in spite of this knowledge, Krajca merely treated Brown for nausea and placed Brown in an isolated cell rather than securing emergency medical services. *Id.* Plaintiffs have also produced evidence suggesting that Nurse Krajca believed she would have received an reprimand from Dr. Bolin for sending Brown to the hospital. Jt. App. at 162.

d. Moving Force

The Court finds, based on the evidence discussed above, that Plaintiffs have produced evidence raising a genuine issue of material fact regarding whether Dr. Bolin engaged in a widespread practice or custom of intimidating nurses and discouraging nurses from seeking emergency care for inmates with serious medical needs. The evidence also raises issues of fact as to whether Defendant Callahan was aware of and adopted or maintained the custom or policy of nurse intimidation. Callahan testified that he was aware that Bolin "gripes all the time" at employees, and that Bolin has a common reputation for not wanting to be bothered. In addition, while the affidavits of Pathena

Tweed and Dawn Wilkinson do not set out specifically what information was given to Sheriff Callahan regarding Dr. Bolin's treatment of nurses, it is reasonable to infer that Sheriff Callahan was told about the specific incidents noted in the affidavits, including details concerning treatment of the inmate with low blood sugar and the inmate that had been raped. The Court must decide all reasonable doubts and inferences in the light most favorable to the non-movant, and therefore finds the affidavits raise an issue of fact regarding whether Callahan was aware that Dr. Bolin intimidated nurses and discouraged them from seeking emergency care for inmates with serious medical needs *See Walker*, 853 F.2d at 358.

In addition, there is evidence suggesting that the alleged policy or custom of nurse intimidation is itself is a repudiation of constitutional rights and is the moving force of the constitutional violations complained of here. *See Cozzo*, 279 F.3d at 289. There is evidence that Nurse Krajca believed she would have received an "ass chewing" from Dr. Bolin had she sent inmate Brown to the hospital, raising a genuine issue of fact regarding whether Nurse Krajca realized that Brown was in need of medical attention, but failed to provide such attention because of Dr. Bolin's policy or custom of discouraging nurses from seeking emergency care for inmates with serious medical needs. The Court finds that this evidence raises genuine issues of material fact regarding whether a policy of nurse intimidation was adopted by Defendant Callahan, and was a moving force behind violation of Brown's constitutional rights.

Defendant Callahan argues that because Wichita County had a Health Services Plan in place that was

approved by the Texas Commission on Jail Standards, Callahan cannot be held liable. The Court does not find that mere adoption of an approved health services plan insulates one from liability, particularly where evidence raises issues regarding whether that plan was followed. *See* Defendant's Brief (stating that the Wichita County health services plan requires procedures for efficient and prompt care for acute and emergency situations).

2. Failure to Supervise or Train

Defendant Callahan also argues that summary judgment is appropriate because Plaintiffs have not produced any evidence of any failure to supervise or train jail staff. Callahan notes that the jail staff receive the appropriate level of state-mandated training.

Plaintiffs allege that Defendant Callahan permitted the jail nurses to act outside their nursing authority by allowing them to assess, diagnose, unlawfully prescribe medications, act as on-call nurses, and make final treatment decisions. Plaintiffs also allege that Defendant Callahan failed to enforce the professional services contract entered into between Bolin and Wichita County. Plaintiffs argue that this lack of supervision created the dangerous environment that resulted in Brown's death. In support of these allegations, and in addition to the evidence discussed above, Plaintiffs have produced the testimony of Defendants Bolin and Callahan, and also point the Court to the professional services contract between Dr. Bolin and Wichita County.

a. Callahan's Testimony

Callahan testified that the County delegated responsibility to Dr. Bolin for inmate health care, and that it was the expectation of the Sheriff's Office that Bolin would supervise the professional activities of the jail nursing staff. *Id.* at 349-56. Callahan stated that, while he has the power to hire and fire nurses, Bolin is responsible for supervising the nurses' provisioning of medical care. *Id.* Defendant Callahan stated that if the jail physician was not supervising the nurses in their professional activities, then there was no one at the jail supervising the nurses in their professional activities. *Id.* at 358. Additionally, as discussed above, the Sheriff testified that when jail nurses complained about Dr. Bolin's treatment of them, Callahan handled the situation by telling Bolin to "sweeten up" and to "get a little nicer" and by instructing jail nurses to put up with it. *Id.* at 375-76.

b. Bolin's Testimony

In contrast to Callahan's testimony, Dr. Bolin testified that he is not the jail nurses' supervisor, and that the sheriff is. *Id.* at 319-20. Dr. Bolin stated that he only supervises jail nurses when he is physically present at the jail facilities or if the nurses call him on the phone, and does not supervise nurses otherwise. *Id.* at 318-19. Bolin testified that he was not Nurse Krajca's employer, but that if he was, he would have discussed with her in depth the problems with the way she handled inmate Brown's medical treatment. *Id.* at 312. Bolin testified that a puddle of blood 1 to 1.5 feet by 2 to 2.5 feet is a significant amount of blood, and that he would be critical of Krajca for not sending Brown to the hospital. *Id.* at 309-10.

c. Professional Services Contracts

Plaintiffs have produced the service contract between Dr. Bolin and Wichita County, which provides that "[t]he Contractor (Bolin) will supervise the professional activities of the Jail Nursing Staff" and that "[i]n all other matters, the Sheriff will supervise these persons." *Id.* at 58. The contract also states that "[t]he Contractor (Bolin) shall provide medical care for inmates needing emergency treatment in the emergency room and medical treatment when admitted to the hospital" and that "emergency care will also cover 24 hour telephone coverage by a licensed physician." *Id.* at 56.

d. Evidence of failure to supervise

The Court finds that Plaintiffs have produced evidence raising a genuine issue of material fact regarding whether Defendant Callahan failed to supervise the jail medical staff. Plaintiffs have produced evidence that suggests that jail nurses were completely unsupervised in providing medical care whenever Dr. Bolin was not physically present at the jail.[3] In addition, there is evidence suggesting that Defendant Callahan, who is responsible under state law for the safety of inmates at the Wichita County jail, responded to evidence of nurse intimidation by speaking with Bolin two or three times over the course of ten or twelve years, asking Bolin to "sweeten up" and by telling the jail nurses to put up with it. Jt. App. at 375-76; TEX. LOCAL GOV'T CODE ANN. § 351.041(a) (Vernon Ann. 2007). The Court finds this evidence raises genuine issues of fact regarding whether Callahan failed to supervise the jail medical staff.[4]

e. Causal Link

Further, the Court finds that Plaintiffs have produced evidence suggesting a causal link exists between Callahan's failure to supervise and violation of constitutional rights. As noted above, there is evidence suggesting that Callahan failed to properly supervise Dr. Bolin after becoming aware that Dr. Bolin intimidated nurses and discouraged them from seeking emergency care for seriously ill inmates. In addition, there is evidence suggesting that Dr. Bolin's opposition to nurses seeking emergency care for sick inmates resulted in nurses, specifically Nurse Krajca, not calling Dr. Bolin or transporting inmate Brown to the hospital, even though Brown had serious medical needs requiring attention, and Krajca was aware of these needs. The Court finds that this evidence demonstrates that there is a fact issue regarding whether Callahan's failure to supervise the jail medical staff resulting in violation of Plaintiffs' rights.

f. Deliberate Indifference

Finally, the Court finds that Plaintiffs have produced evidence suggesting that Callahan's failure to supervise amounts to deliberate indifference. Fact issues exist regarding whether Defendant Callahan knew that Dr. Bolin engaged in a practice of intimidating nurses and discouraging them from seeking emergency care for inmates with serious medical needs, but failed to take appropriate supervisory measures. To the extent a custom of nurse intimidation existed, and Callahan was aware of the custom, the Court finds that the obviousness of the risk of harm from such a custom is sufficient to raise a fact issue regarding whether

Callahan was aware of facts from which the inference could be drawn that his failure to supervise posed a substantial risk of serious harm to inmates. In addition, the obviousness of the risk of harm also creates a genuine fact issue regarding whether Defendant Callahan in fact drew the inference that his failure to supervise would cause harm. *See Smith*, 158 F.3d at 912; *Farmer*, 511 U.S. at 842 (stating that a fact-finder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious).

Callahan repeatedly points out in his briefing that detention officers Sours and Greene were not medically qualified to determine whether the large puddle of vomit found next to Jason Brown on July 23, 2004 contained blood. Def's Brief at 3-4, 13-14, 18, 20-21. While Sours and Greene made statements shortly after Brown's death indicating that they found Brown lying next to a large puddle of blood and reported this to Nurse Krajca, Callahan submits affidavits from these detention officers, executed several years after the events in question, in which Sours and Greene aver that they do not know if the vomit actually contained any blood and are not qualified to make such a determination since they have no formal medical training. Jt. App. at 94 (Greene's affidavit, dated October 24, 2007, indicating he has no formal training enabling him to tell whether vomit contains blood); 103 (Sours' affidavit, dated October 24, 2007, stating same); 162-63 (Sours Memo, dated August 3, 2004, stating that he saw a large puddle of blood on the floor next to Brown's bunk, and that he then asked Brown "what could have caused him to throw up blood"); 170 (handwritten memo from Greene, requested the day after Brown's death by Callahan, Chief Yoder, and the

Texas Rangers, stating that "[w]hen we got there we seen (sic) a big puddle of blood on the floor").

Defendant Callahan also discusses at length the expert testimony of Dr. Browne, who testified that inmates often test the jail system by feigning illness for secondary gain. Def's Brief at 17-21. Defendant argues, based on this opinion, that "many of the jail inmates feel that medical (sic) can just get them out of jail much like a judge dismissing charges and releasing them." *Id.* at 18.

Defendant Callahan appears to argue that Nurse Krajca and the jail staff were entitled to ignore that Brown may have thrown up blood because no one with medical training confirmed that Brown had vomited up blood and also because inmates lie. Defendant appears to suggest that the jail had a policy of disregarding inmates' medical complaints as fabrications unless a nurse or doctor could personally verify the complaints.

That the jail had such a policy is suggested by the testimony of Nurse Ingram, another Wichita County jail nurse. Jt. App. at 394. Nurse Ingram testified that if an inmate was complaining to her or another nurse at Wichita County that he had thrown up blood, the complaint itself is not enough to warrant contacting the doctor unless she or another nurse actually saw the blood. *Id.* Nurse Ingram stated that, although Jason Brown complained to Nurse George at book-in that he was vomiting up blood, Nurse George had no obligation to review Brown's medical history forms, which stated that he had esophageal varices. *Id.* Nurse Ingram acknowledged that esophageal varices can cause a person to bleed to death, resulting in the person

throwing up blood, but stated that because Nurse George didn't see any blood, there was no need to further investigate Brown's medical complaints. *Id.* at 397-398. Similarly, a statement from detention officer Sours suggests that Nurse Krajca wanted verification that Brown had vomited blood. Sours stated in his memo drafted on August 3, 2004 that, on the night Brown died, Nurse Krajca asked Sours whether anyone actually saw Brown throw up blood, to which Sours responded "Kaye, I had to clean it up." Jt. App. at 162.

To the extent Defendant Callahan is attempting to argue that there was no underlying constitutional violation because Nurse Krajca and detention officers were entitled to ignore Brown's complaints, as no one with medical training verified that Brown vomited blood and inmates lie, this argument fails to achieve its goal. The Court notes that there is no evidence suggesting that Brown fabricated any symptoms, and regardless, Nurse Krajca was told that Brown vomited blood by the jail's own detention officers and other inmates, not Jason Brown. There is evidence suggesting that Jason Brown was incoherent and unresponsive when the detention officers found him next to a puddle of vomit/blood.

Regardless, to the extent resolution of the issue of whether Brown vomited blood is material, the Court finds such an issue is matter for the jury. *See Keenan v. Tejeda*, 290 F.3d 252, 262 (5th Cir. 2002). Genuine issues of material fact exist regarding whether Defendant Callahan violated Plaintiffs' constitutional rights. Plaintiffs have produced evidence suggesting that Nurse Krajca was aware that Brown needed medical attention, but failed to provide it. In addition, Plaintiffs

have produced evidence suggesting that policies adopted by Callahan, and/or situations that existed because of Callahan's failure to supervise, where why Nurse Krajca refused care. Accordingly, the Court finds that fact issues exist regarding whether Defendant Callahan's acts or omissions violated Plaintiffs' constitutional rights.

The Court now considers whether, in light of these factual issues, Defendant Callahan is nevertheless entitled to summary judgment on his defense of qualified immunity.

3. Qualified Immunity

In determining whether summary judgment on the ground of qualified immunity is appropriate, the Court first considers whether Plaintiffs have presented evidence raising a fact issue material to the resolution of the question of whether Defendant Callahan acted in an objectively reasonable manner in view of the existing law and facts available to him. *See Lampkin v. City of Nacagdoches*, 7 F.3d 430, 435 (5th Cir. 1993). If reasonable public officials could differ as to whether Callahan's actions were lawful, Callahan is entitled to immunity. *See Malley*, 475 U.S. at 341 (1986). "Even if a defendant's conduct actually violates a plaintiff's constitutional rights, the defendant is entitled to qualified immunity if the conduct was objectively reasonable." *Zarnow v. City of Wichita Falls, Tex.*, 500 F.3d 401, 408 (5th Cir. 2007) (quoting *Pfannstiel v. City of Marion*, 918 F.2d 1178, 1183 (5th Cir. 1990)). In addition, the Court must also consider whether Plaintiffs have raised an issue of fact regarding whether the defense of qualified immunity is

unavailable because the defendant is plainly incompetent or knowingly violated the law. *See Malley*, 475 U.S. at 341.

After considering the evidence and the applicable law, the Court finds that genuine issues of material fact exist regarding whether Defendant Callahan acted in an objectively reasonable manner in view of the clearly established law, in light of the facts available to him, at the time of the conduct in question. Plaintiffs have produced evidence raising genuine issues of material fact regarding whether Defendant Callahan knew that Dr. Bolin intimidated nurses and discouraged them from seeking emergency care for inmates with serious medical needs, and also knew that harm would result from such a policy. In addition, Plaintiffs have produced evidence that Callahan adopted and/or acquiesced to this custom and failed to respond with any meaningful supervisory action. Thus, the Court finds, based on the evidence before it, that Plaintiffs have raised a fact issue as to whether Callahan was objectively reasonable in view of the facts known to him, and in light of clearly established law, at the time of the conduct in question.[5]

Accordingly, Defendant Callahan's Motion for Summary Judgment is hereby **DENIED** as to Plaintiffs' claims under the Fourteenth Amendment.

C. Evidentiary Objections

In addition to the affidavits of Pathena Tweed and Dawn Wilkinson, Defendant also objects to the Horowitz letter, the opinion of Dr. Keikbusch, and the affidavit of John R. Hyatte.

Plaintiffs object to various statements within the affidavits of Defendant Callahan, Dr. Browne, and Gary Pinkerton. As noted above in footnote 4, the Court declines to strike the affidavits of Pathena Tweed and Dawn Wilkinson, but will not consider hearsay or speculation. With respect to the remaining objections, the Court overrules these objections as moot, as this evidence was not relied upon in the Court's determination.

D. Punitive Damages

Defendant Callahan argues that Plaintiffs cannot recover punitive damages from him for any violation of 42 U.S.C. § 1983 because such damages are prohibited by the Texas Wrongful Death Act and the Texas Constitution. Plaintiffs contend that Texas law does not limit the available damages in an action under section 1983.

The Fifth Circuit has held that because federal law does not address the availability of a wrongful death remedy, courts look to state law authorizing wrongful death claims in assessing whether a plaintiff has a cause of action under 42 U.S.C. § 1983. *Brazier v. Cherry*, 293 F.2d 401 (5th Cir. 1961). In *Baker v. Putnal*, the Fifth Circuit stated that "it is the law of this circuit that individuals who are within the class of people entitled to recover under the Texas wrongful death statute have standing to sue under § 1983 for their own injuries resulting from the deprivation of decedent's constitutional rights." *Baker v. Putnal*, 75 F.3d 190, 195 (5th Cir. 1996).

Here, there is no dispute that Texas law entitles parents to maintain an action for the wrongful death of their child, and therefore Brown's parents have standing to pursue their wrongful death claims brought pursuant to 42 U.S.C. § 1983. *See* Texas Constitution, Art. 16, § 26; Tex. Civ. Prac. & Rem. Code § 71.002. In addition, there is no dispute that Texas law prohibits parents from recovering punitive damages in wrongful death actions brought pursuant to state law. *See id.* At issue is whether the prohibition on the recovery of punitive damages in wrongful death actions brought by parents pursuant to Texas law bars recovery of punitive damages in wrongful death actions brought by parents pursuant to 42 U.S.C. § 1983. Neither party has presented a case squarely addressing this issue.

The Court finds it necessary to defer ruling and to require supplemental briefing on this issue. The parties are hereby **ORDERED** to file a supplemental brief on this issue by **5:00 p.m.** on **August 18, 2009**. The brief shall not exceed fifteen pages.

IV. Conclusion

For the foregoing reasons, the Court finds that Defendant Callahan's Motion for Summary Judgment (Doc. # 126) should be and is hereby **GRANTED in part, and DENIED in part.**

The Court finds that genuine issues of material fact exist regarding Plaintiffs' claims under the Fourteenth Amendment brought pursuant to 42 U.S.C. § 1983.

The Court finds that summary judgment is appropriate with respect to Plaintiffs' claims under the Fourth

Amendment brought pursuant to 42 U.S.C. § 1983, and these claims are hereby **DISMISSED with prejudice.**

SO ORDERED this 4th day of **August, 2009.**

Reed O'Connor
UNITED STATES DISTRICT JUDGE

Footnotes

1 Because Plaintiffs complain that jail personnel provided inadequate medical care, this case is an episodic act or omission claim, which requires Plaintiffs to show Defendants acted with deliberate indifference. *See Hare*, 74 F.3d at 645.

2 Sheriff Callahan moves to strike these affidavits, arguing that the affidavits consist of conclusory testimony containing information outside the affiants' personal knowledge that should be excluded and stricken pursuant to Rule 602 of the Federal Rules of Evidence. Callahan also argues that the affidavits contain hearsay. The Court finds that, while the affidavits submitted by Plaintiffs contain a few statements properly characterized as hearsay and speculation, the Court may consider those nonhearsay statements within the affidavits that are based on the affiants' personal knowledge. Accordingly, the Court declines to strike these affidavits in whole, but does not consider hearsay or speculation.

3 The Court notes that Dr. Bolin testified that he was only present at the jails during "doctor's call" which generally occurred three times a week - on Mondays and Thursdays at the annex facility, and on

Wednesdays at the downtown jail facility. Jt. App. at 290-91. Bolin testified that he estimates that he spends 25-33% of his time working for Wichita County, spending the rest of his time in private practice. *Id.*

4 Plaintiffs also allege Callahan is liable for failure to train jail staff, but have failed to produce any evidence of specific training deficiencies. While Plaintiffs have produced evidence suggesting that nurses performed duties without proper supervision, and arguably the nurses would not have needed supervision had they received advanced training, the Court finds that Plaintiffs' claims are properly considered claims for failure to supervise jail staff.

5The Court notes that it was clearly established at the time in question that pretrial detainees have a Fourteenth Amendment right not to have their serious medical needs met with deliberate indifference by jail officials. *Hare*, 74 F.3d at 650.

No. 09-10843

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JANIS L. BROWN, Individually, and as Personal Representative of the Estate of Jason Ray Brown, Deceased; BILLY RAY BROWN, Plaintiffs - Appellees

v.

THOMAS J. CALLAHAN, Sheriff of Wichita County, Texas, in his Individual and Official Capacity, Defendant - Appellant

Filed 11/18/2010

***

ON PETITION FOR REHEARING

Before JONES, Chief Judge, PRADO, Circuit Judge, and OZERDEN, District Judge. *

IT IS ORDERED that the petition for rehearing is denied.

Footnote

*District Judge of the Southern District of Mississippi, sitting by designation.

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No. 10-1045

In the
Supreme Court of the United States

JANIS L. BROWN, INDIVIDUALLY AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF JASON RAY BROWN, DECEASED, ET AL.,

Petitioners,

v.

THOMAS J. CALLAHAN, INDIVIDUALLY AND IN HIS OFFICIAL CAPACITY AS SHERIFF, WICHITA COUNTY, TEXAS,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF IN OPPOSITION

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April 25, 2011

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QUESTIONS PRESENTED

On October 7, 2010, after oral argument, the United States Court of Appeals for the Fifth Circuit ("the Fifth Circuit") determined that Sheriff Callahan is entitled to qualified immunity, thereby reversing a previous decision of the United States District Court for the Northern District of Texas. The present Petition for a Writ of Certiorari followed.

Three questions are presented:

1. Whether the Fifth Circuit erred in determining that the undisputed evidence shows that no causal link connects Jason Brown's ("Brown") death to any action or inaction by Sheriff Callahan, including the "unlawful medical care" of which Petitioners complain.

2. Whether the Fifth Circuit erred in finding that well-settled law applied to the undisputed evidence required a conclusion that Sheriff Callahan's actions did not meet the extremely high standard of deliberate indifference with respect to his training and/or supervision of Dr. Bolin and the jail nurses.

3. Whether the Fifth Circuit erred in finding that well-settled law applied to the undisputed evidence required a conclusion that Sheriff Callahan's actions did not meet the extremely high standard of deliberate indifference with respect to his adoption of jail policies or procedures.

LIST OF PARITES

Pursuant to Supreme Court Rule 24(b), Sheriff Callahan provides the following list of parties to the proceeding in the Court whose judgment is under review:

1. Janis L. Brown, Individually, and as Personal Representative of the Estate of Jason Ray Brown, Deceased; Petitioner;

2. Billy Ray Brown; Petitioner;

3. Thomas J. Callahan, Sheriff of Wichita County, Texas, in his Individual and Official Capacity; Respondent.

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The opinion of the Fifth Circuit which Petitioners challenge was reported at 623 F.3d 248 (5th Cir. 2010). The opinion of the United States District Court for the Northern District of Texas, Wichita Falls Division, was not selected for publication in the Federal Supplement Reporter.

STATEMENT OF JURISDICTION

The Fifth Circuit entered the decision of which Petitioners complain on October 7, 2010, and Petitioner's Motion for Rehearing wad denied on November 18, 2010. Judgment issued as mandate to the District Court on December 6, 2010. Because judgment has been rendered in this case, this Court has jurisdiction over Petitioner's Petition for Writ of Certiorari. 28 U.S.C. § 1254(1).

RELEVANT LEGAL AUTHORITIES

Pursuant to Supreme Court Rule 24(f), Sheriff Callahan provides the following references to the legal authorities relevant to the present Petition for Writ of Certiorari:

42 U.S.C. § 1983:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the

> Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

United States Constitution, Amendment XIV, § 1

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

STATEMENT OF THE CASE

A. The Events Giving Rise to This Appeal

On or about July 22, 2004, Brown was arrested in Burkburnett, Texas, and was transported to the Wichita County Jail ("the Jail") at approximately 4:00 p.m. On the evening of July 23, 2004, at approximately 11:42 p.m., inmates in tank 7/6 called the control room by using the emergency call button

and notified the control room operator that Brown had thrown up blood on the floor. (USCA5, Vol. 10, Jt. App. 162.) Deputies Greene and Sours responded to the inmates' call. (USCA5, Vol. 10, Jt. App. 162, 170.) When they arrived, Deputies Greene and Sours saw a puddle of vomit on the floor near the back of the tank. (USCA5, Vol. 10, Jt. App. 162, 170.) Although they described the vomit as blood in their statements, Deputies Greene and Sours referred to the vomit as "blood" because the inmates reported it as such when they called the control room to report the incident. Deputies Greene and Sours did not know if the vomit actually contained any blood and are not qualified to make such a determination due to their lack of medical training. Deputy Greene recalls the puddle of vomit covering approximately 14 by 16 inches of the floor of the cell. (USCA5, Vol. 10, Jt. App. 170.)

Deputy Sours then had a discussion with Brown regarding medications he was taking and possible causes for his condition. After the conversation with Brown, Deputies Greene and Sours asked the control room officer to call Nurse Kaye Krajca to advise her of the situation. (USCA5, Vol. 10, Jt. App. 162, 170, 183.) Nurse Krajca instructed the control room officers to give Brown liquid antacid. (USCA5, Vol. 10, Jt. App. 162, 170.) Deputy Greene gave Brown the antacid, and he and Deputy Sours left the tank. (USCA5, Vol. 10, Jt. App. 162, 170.)

Later, an inmate in Tank 7/6 pushed the emergency call button again to contact the control room and reported that Brown was complaining of pain. (USCA5, Vol. 10, Jt. App. 162, 170.) Upon receiving the complaint, Nurse Krajca was called once again and recommended that Brown be given suppositories.

(USCA5, Vol. 10, Jt. App. 162, 170-71.) Deputy Sours then proceeded to the control room and called Nurse Krajca regarding Brown's condition. (USCA5, Vol. 10, Jt. App. 162, 170.) At approximately 2:25 a.m., Deputies Greene and Sours went into tank 7/6 and offered the suppositories to Brown. (USCA5, Vol. 10, Jt. App. 162, 170-71.) However, Brown refused to take the suppositories. (USCA5, Vol. 10, Jt. App. 162, 171.) Since he would not communicate with them, Nurse Krajca was called back and advised of Brown's condition. (USCA5, Vol. 10, Jt. App. 171, 183.) Nurse Krajca then proceeded to the tank to examine Brown. (USCA5, Vol. 10, Jt. App. 171, 183.) When she arrived at approximately 2:55 a.m., Nurse Krajca and Deputies Greene and Sours went to tank 7/6. (USCA5, Vol. 10, Jt. App. 171, 183.) Nurse Krajca tried talking to Brown, and he eventually communicated with her. (USCA5, Vol. 10, Jt. App. 171, 183.) Nurse Krajca told Deputies Greene and Sours to move Brown to medical solitary. (USCA5, Vol. 10, Jt. App. 171, 183.) Brown was placed in medical solitary cell S/3 at 3:12 a.m. (USCA5, Vol. 10, Jt. App. 171, 183.)

Once Brown was in medical solitary, Nurse Krajca tried to get Brown to take the suppository. (USCA5, Vol. 10, Jt. App. 162, 171, 183.) Deputies Greene and Sours helped Brown up, and Nurse Krajca administered the suppository. (USCA5, Vol. 10, Jt. App. 162, 171, 183.) They then exited Brown's medical solitary cell. (USCA5, Vol. 10, Jt. App. 162, 171, 183.)

Deputies Greene and Sours checked on Brown throughout the remainder of the shift and observed him sleeping throughout the early morning hours. (USCA5, Vol. 10, Jt. App. 162, 171.) At approximately 5:29 a.m. on July 24, Deputies Greene and Sours fed

the inmates breakfast. (USCA5, Vol. 10, Jt. App. 162, 171.) When they arrived at Brown's solitary cell, they opened the food portal and alerted Brown that his breakfast was served. (USCA5, Vol. 10, Jt. App. 162, 171.) Deputy Sours asked Brown if he wanted to eat and Brown indicated that he did not wish to eat. (USCA5, Vol. 10, Jt. App. 162, 171.) For the remainder of the morning, Deputies Greene and Sours observed Brown sleeping. (USCA5, Vol. 10, Jt. App. 162, 171.) Their shifts ended at 7:00 a.m. (USCA5, Vol. 10, Jt. App. 162, 171.) Deputy Sours observed that at the end of the shift, Brown's condition did not appear to have changed. (USCA5, Vol. 10, Jt. App. 162, 171.)

On July 24, 2004, Deputies Yeager, Dickerman, and Geary worked the 7:00 a.m. to 3:00 p.m. shift and observed Brown numerous times during that time. (USCA5, Vol. 9, Jt. App. 087; Vol. 10, Jt. App. 162, 171.) Deputy Yeager regularly checked on Brown by looking through the window in the door to make sure that he was breathing and his position periodically changed. (USCA5, Vol. 10, Jt. App. 186.) At 10:38 a.m., Deputy Yeager heard Brown making noises while laying on his bunk. (USCA5, Vol. 10, Jt. App. 186.) Deputy Yeager checked on him, and Brown indicated that he was alright. (USCA5, Vol. 10, Jt. App. 186.)

At approximately 11:30 a.m., Deputies Yeager and Dickerman stopped at Brown's cell to serve him lunch. (USCA5, Vol. 9, Jt. App. 87; Vol. 10, p. 186.) When Deputy Dickerman told Brown that the meal had arrived, Brown made several noises. (USCA5, Vol. 9, Jt. App. 87-88.) Deputy Dickerman asked once again if he wanted to eat and Brown turned his head and indicated that he did not want to eat. (USCA5, Vol. 9,

Jt. App. 87-88.) Deputy Yeager was on the other side of the tray cart, preparing to hand Deputy Dickerman a tray for Brown. (USCA5, Vol. 10, Jt. App. 186.) Deputy Yeager did not hear a response, but saw Brown through the serving door move his arm up around his head as if to indicate that he did not want a food tray. (USCA5, Vol. 10, Jt. App. 186.) It is not unusual for inmates to respond in such a manner. (USCA5, Vol. 10, Jt. App. 186.) From that time on Deputy Yeager observed Brown sleeping. (USCA5, Vol. 10, Jt. App. 186.) Specifically, Deputy Yeager observed Brown sleeping at 12:26 p.m., 12:58 p.m., 2:30 p.m. and 2:50 p.m. (USCA5, Vol 9, Jt. App. 90; Vol. 10, Jt. App. 91-119.)

Throughout his shift, Deputy Dickerman observed Brown in different positions and in different stages of dress. (USCA5, Vol. 9, Jt. App. 87-88.) Brown always appeared to be breathing when Deputy Dickerman observed him. (USCA5, Vol. 9, Jt. App. 87-88.) Deputy Dickerman also observed Brown sleeping at 1:35 p.m. and 1:57 p.m. (USCA5, Vol. 9, Jt. App. 87-88.)

Deputies Parish and Whatley worked the second shift from 3:00 to 11:00 p.m. on July 24, 2004. (USCA5, Vol. 10, Jt. App. 188.) At 3:55 p.m., during Deputy Whatley's initial patrols of cells 7/3-7/6 and S/3-S/4, he observed Brown lying on his bunk wearing only a shirt. (USCA5, Vol. 10, Jt. App. 188.) Deputy Whatley also observed Brown move. (USCA5, Vol. 10, Jt. App. 188.) At mealtime while Deputy Whatley was serving trays, he opened the food compartment on Brown's cell door and told Brown that a meal was being served. (USCA5, Vol. 10, Jt. App. 188.) Brown

indicated that he did not wish to eat his meal. (USCA5, Vol. 10, Jt. App. 188.)

As Deputy Whatley checked Brown later during his shift, he observed that Brown had moved and changed positions. (USCA5, Vol. 10, Jt. App. 188.) Later during his shift, Deputy Whatley observed Brown's chest was rising and falling and believed that Brown was sleeping. (USCA5, Vol. 10, Jt. App. 188.) Deputy Whatley observed Brown's skin coloring several times and it appeared normal and did not seem to change. (USCA5, Vol. 10, Jt. App. 188.) He observed Brown sleeping at 4:00 p.m., 6:00 p.m., 7:00 p.m., 8:00 p.m., 9:03 p.m., 9:26 p.m. and 9:59 p.m. (USCA5, Vol 9, Jt. App. 90; Vol. 10, Jt. App. 91-119.

At approximately 10:00 p.m. on July 24, 2004, Deputy Parish briefly observed Brown when he entered his cell. When Deputy Parish briefly observed Brown, he was asleep on his bunk. Deputy Parish did not notice anything unusual.

Later in the evening of July 24, 2004, Deputy Greene returned to the jail and worked the third shift, which began at 11:00 p.m. (USCA5, Vol. 10, Jt. App. 171.) At approximately 11:30 p.m., Deputy Ryan called Deputy Greene and asked him to come to Brown's medical solitary cell to assist with checking on Brown. (USCA5, Vol. 10, Jt. App. 190.) Upon entering Brown's cell, Deputy Greene tried unsuccessfully to get Brown to speak to him and gently shook him on the shoulder. (USCA5, Vol. 10, Jt. App. 190.) When Brown did not respond, Deputy Greene tried to find a pulse on Brown's wrist, but was unable to do so. (USCA5, Vol. 10, Jt. App. 190.) Deputy Greene and Officer Ryan immediately went to the control room to

advise Lt. Enoch of their findings, and Lt. Enoch then called for emergency assistance. (USCA5, Vol. 10, Jt. App. 190.) Deputies Greene and Ryan returned to Brown's cell and covered Brown from the waist down with a blanket. (USCA5, Vol. 10, Jt. App. 190.) An autopsy of Brown's body later revealed that he had suffered from a gastrointestinal hemorrhage due to rupture of the esophageal varicies caused by chronic viral hepatitis with cirrhosis of the liver. (USCA5, Vol. 10, Jt. App. 190.)

B. Sheriff Callahan's Policies Regarding Healthcare in the Jail

Sheriff Callahan has been the Wichita County Sheriff since being elected in 1986. (USCA5, Vol. 9, Jt. App. 33.) During his twenty-three year tenure as Wichita County Sheriff, Wichita County has always had a policy of providing reasonable medical care to pretrial detainees and of not violating the constitutional rights of inmates housed in the Jail. (USCA5, Vol. 9, Jt. App. 33.) Additionally, while he has been sheriff, the Wichita County Sheriff's Department has not had a policy of being deliberately indifferent to the serious medical needs of its inmates. (USCA5, Vol. 9, Jt. App. 33.)

Wichita County contracted with a jail physician to oversee the health services plan for the Wichita County Sheriff's Office. (USCA5, Vol. 9, Jt. App. 34.) The Record shows that Sheriff Callahan had no knowledge that Brown was incarcerated in the Jail at any the time relevant to this litigation, he had no contact with Brown while he was in the Jail, no one had any communication with him regarding Brown while he was in the Jail, and gave no instructions or

orders regarding Brown during his incarceration in the Jail. (USCA5, Vol. 9, Jt. App. 34.)

Sheriff Callahan is of the opinion that the Jail physician, Dan Bolin, M.D., is an excellent physician who handles his job as jail physician in a professional and serious manner. (USCA5, Vol. 9, p. 2194.) It was Dr. Bolin's responsibility to supervise the nurses in their professional capacities, while Sheriff Callahan supervised the nurses in their administrative capacities. (USCA5, Vol. 10, p. 2396; Vol. 3, p. 745; Vol. 11, p. 2515.) Additionally, Sheriff Callahan had personally drafted a Health Services Plan which had been approved by the Texas Commission on Jail Standards–the agency which regulates and certifies jails in the State of Texas. (USCA5, Vol. 11, p. 2510, 2514.) The policy, custom and practice of the Wichita County Sheriff's Department relating to health services and medical care is fully set forth in the plan. The Jail facility itself has also been approved by the Texas Commission on Jail Standards. The Health Services Plan can be found in the Record on Appeal at Volume 10, pages 2433 through 2441, and represents Sheriff Callahan's general orders regarding administering health care to inmates confined in the Jail. (USCA5, Vol. 11, p. 2510.) According to the Health Services Plan, Sheriff Callahan ordered the Jail's medical staff to immediately transport inmates to the hospital in case of emergency medical situations. (USCA5, Vol. 11, p. 2438.) The Health Services Plan specifically gives the authority to jail nurses to determine if transportation to the hospital is necessary, and directs jail nurses to order transportation to the hospital in case of emergency medical situations. (*Id.*) Further, Sheriff Callahan instructed the nursing staff to call Dr. Bolin "at any

time they need to." (*Id.*) As mentioned above, Sheriff Callahan instructed the Jail's medical staff to transport seriously ill inmates to the hospital at any time they deemed it necessary, and specifically gave the nursing staff the authority to do so. (USCA5, Vol. 11, p. 2438.)

The medical services plan calls for six full-time nurses to care for inmates in the Jail. (USCA5, Vol. 9, Jt. App. 34.) If there is not a nurse on physically present at the Jail, there is always a nurse on call who is immediately available to detention staff. (USCA5, Vol. 9, Jt. App. 34.) Additionally, Dr. Bolin is always on call if needed by the nurses. (USCA5, Vol. 9, Jt. App. 34.) If Dr. Bolin is out of town or otherwise unavailable, he provides access to another doctor who is immediately available and on call if needed. (USCA5, Vol. 9, Jt. App. 34-35.)

In the year Brown's death occurred, Wichita County spent more than $380,000 in payroll for the medical staff at the Jail. (USCA5, Vol. 9, Jt. App. 35.) In the last ten years, Wichita County has averaged more than $160,000 in expenditures for drugs and other medical supplies that have been used in providing medical services in the Jail to the inmates. (USCA5, Vol. 9, Jt. App. 35.) Further, the ten year average in dental expenses provided to the inmates is approximately $33,000 per year. (USCA5, Vol. 9, Jt. App. 35.) The Wichita County Sheriff's Office does not have to pay for medical services provided by United Regional Health Care Systems, so those expenses are not included in the foregoing figures. (USCA5, Vol. 9, Jt. App. 35.) If an inmate needs emergency medical care due to a condition that is deemed by jail and/or medical staff at the jail to be life threatening, they are

to be transported to United Regional Health Care System's Emergency Room for treatment. (USCA5, Vol. 9, Jt. App. 35.) Common sense is used in determining what constitutes an emergency by the shift supervisor and/or the nursing staff at the jail. (USCA5, Vol. 9, Jt. App. 35.) It is the policy, custom and practice of Wichita County that if there is any question as to the seriousness of the situation, the situation is handled as an emergency, and then a shift supervisor uses his or her best judgment. (USCA5, Vol. 9, Jt. App. 35.)

In short, the Record clearly shows that Brown's death was not a result of any act or inaction of any person working for Wichita County. Additionally, the Record shows that Sheriff Callahan did not have any subjective knowledge that his training and/or supervision and/or policies regarding the Jail would result in any person being denied medical care.

SUMMARY OF THE ARGUMENT

The Record clearly shows that Sheriff Callahan is entitled to qualified immunity from Petitioner's claims. Specifically, there is absolutely no causal connection between Brown's death and any action or inaction by Sheriff Callahan, any policy he implemented, or any training, and/or supervision which he provided. There is no evidence that Sheriff Callahan was deliberately indifferent to any of Brown's or Petitioners' constitutional rights.

ARGUMENT

A. Qualified Immunity Standard

Public officials acting within the scope of their authority are generally shielded from civil liability by the doctrine of qualified immunity. *See Harlow v. Fitzgerald*, 457 U.S. 800, 102 S. Ct. 2727, 73 L. Ed. 2d 396 (1982). "The doctrine of qualified immunity serves to shield a government official from civil liability for damages based upon the performance of discretionary functions." *Cozzo v. Tangipahoa Parish Council-President Gov't*, 279 F.3d 273, 284 (5th Cir. 2002). "The Supreme Court has characterized the doctrine as protecting 'all but the plainly incompetent or those who knowingly violate the law.'" *Id.* (quoting *Malley v. Briggs*, 475 U.S. 335, 341, 106 S. Ct. 1092, 89 L. Ed. 2d 271 (1986)).

In assessing qualified immunity, courts must conduct a bifurcated analysis. *See, e.g., Collins v. Ainsworth*, 382 F.3d 529, 537 (5th Cir. 2004), *cert. denied*, 547 U.S. 1055, 126 S. Ct. 1661, 164 L. Ed. 2d 397 (2006). The qualified immunity analysis is comprised of two parts which may be considered in any order. *Pearson v. Callahan*, --- U.S. ---, 129 S. Ct. 808, 818, 172 L. Ed. 2d 565 (2009). The initial inquiry asks whether, taken in the light most favorable to the party asserting the injury, the facts alleged show that the official's conduct violated a constitutional right. *See Scott v. Harris*, 550 U.S. 372, 377, 127 S. Ct. 1769, 1774, 167 L. Ed. 2d 686 (2007). "If, and only if, the court finds a violation of a constitutional right, 'the next, sequential step is to ask whether the right was clearly established ... in light of the specific context of the case.'" *Id.* To be clearly established for purposes

of qualified immunity, the contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right. *Pearson*, --- U.S. ---, 129 S. Ct. at 815. The unlawfulness of the defendant's actions must have been readily apparent from sufficiently similar situations, but it is not necessary that the defendant's exact act have been held illegal. *Id.*

If the defendant's actions violated a clearly established constitutional right, the corresponding prong of the analysis determines whether qualified immunity is appropriate, nevertheless, because the defendant's actions were objectively reasonable in light of law which was clearly established at the time of the disputed action. *Malley*, 475 U.S. at 341, 106 S. Ct. 1092. An official's conduct is objectively reasonable unless all reasonable officials would have realized the particular challenged conduct violated the constitutional provisions sued on. *Anderson v. Creighton*, 483 U.S. 635, 637-38, 107 S. Ct. 3034, 97 L. Ed. 2d 523 (1987)). A plaintiff must allege sufficient facts to demonstrate that no reasonable officer could have believed his actions were proper. *Id.* Whether an official's conduct was objectively reasonable is a question of law for the court, not a matter for the jury.

The usual summary judgment burden of proof is altered in the case of a qualified immunity defense. *Saldana v. Garza*, 684 F.2d 1159, 1163, n. 14 (5th Cir. 1982), *cert. denied*, 460 U.S. 1012, 103 S. Ct. 1253, 75 L. Ed. 2d 481 (1981). Once an official pleads his good faith, the burden then shifts to the plaintiff, who must rebut the defense by establishing that the official's allegedly wrongful conduct violated clearly established law. *Id.* The plaintiff bears the burden of negating

qualified immunity and cannot rest on conclusory allegations and assertions, but must demonstrate genuine issues of material fact regarding the reasonableness of the official's conduct. *Id.*

B. Sheriff Callahan did not exercise deliberate indifference with respect to the training and/or supervision of the nurses or Dr. Bolin, and he is therefore entitled to qualified immunity.

Respondeat superior liability may not be imposed upon supervisors in an action based on Section 1983. *City of Canton v. Harris*, 489 U.S. 378, 385, 109 S. Ct. 1197, 103 L. Ed. 2d 412 (1978). A plaintiff can only succeed on a failure to train claim by demonstrating that an official's failure to train caused a deprivation of plaintiff's rights and the official's failure to train under the circumstances constituted deliberate indifference. *Thompson v. Upshur Cnty.*, 245 F.3d 447, 459 (5th Cir. 2001). "Deliberate indifference is a stringent standard of fault, requiring proof that a municipal actor disregarded a known or obvious consequence of his action." *Bd. of Cnty. Comm'rs of Bryan Cnty., Okla. v. Brown*, 520 U.S. 397, 410, 117 S. Ct. 1382, 1391, 137 L. Ed. 2d 626 (1997). Indeed, "[d]eliberate indifference is an extremely high standard to meet." *Gobert v. Caldwell*, 463 F.3d 339, 346 (5th Cir. 2006). A supervisory defendant "must know about the conduct and facilitate it, approve it, condone it, or turn a blind eye for fear of what they might see. They must in other words act either knowingly or with deliberate, reckless indifference." *Gonzalez v. Ysleta Indep. Sch. Dist.*, 996 F.2d 745, 761 (5th Cir. 1993). To be deliberately indifferent, "the official must both be aware of facts from which the

inference could be drawn that a substantial risk of harm exists, and he must also draw the inference." *Farmer v. Brennan*, 511 U.S. 825, 837, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994); *see also Wilson v. Seiter*, 501 U.S. 294, 111 S. Ct. 2321, 115 L. Ed. 21d 271 (1991). Mere negligence—and even gross negligence—is insufficient to show that a supervisor exercised deliberate indifference. *City of Canton*, 489 U.S. at 388, 109 S. Ct. 1197.

In the present case, Petitioner attempts to argue that the Court should impose individual liability upon Sheriff Callahan based upon the allegation that "Nurse Krajca perform[ed] duties outside the Texas Nurse Practices Act and Texas and Texas law for prescribing medications [which was] . . . causally related to the death of [Brown]." (Pet. For Writ of Cert., pp. 13-14.) Although Petitioners attempt to couch this argument in a novel manner, Petitioners essentially argue that the nurses were improperly supervised. It is important to note that there is absolutely no evidence in the Record which would support Petitioner's allegation that any medications administered to Brown contributed to his death. Conspicuously, Petitioner does not direct the Court to any legal authority which would support the novel argument that a nurse allegedly practicing outside a medical standard of care could subject a county sheriff to individual liability under Section 1983. At most, such a practice would amount to mere negligence rather than deliberate indifference, and would not meet the extremely high burden of showing that a governmental official acted with deliberate indifference. *See City of Canton*, 489 U.S. at 388, 109 S. Ct. 1197.

Further, deliberate indifference requires a plaintiff to show a pattern of violations of constitutional rights. *Estate of Davis v. City of N. Richland Hills*, 406 F.3d 375, 381 (5th Cir. 2005). Petitioner "respectfully disagree[s]" with this well-settled requirement and argues that this case should fall within the extremely narrow exception to this widely-applied rule which was carved out in *Oklahoma City v. Tuttle*, 471 U.S. 808, 105 S. Ct. 2427, 85 L. Ed. 2d 791 (1985). In *Tuttle*, this Court held that a single event could create liability under Section 1983 under a specific set of very narrow circumstances. This Court further discussed the narrow parameters of *Tuttle* in *Connick v. Thompson*, —U.S.—, —S. Ct.—, —L. Ed. 2d—, 2011 WL 1119022 (March 29, 2011). In *Connick*, *supra*, this Court was confronted with a particularly difficult factual situation wherein a man who had been confined on the Louisiana Death Row for fourteen years was exonerated after it was revealed that the Orleans Parish District Attorney's office had purposely secreted exculpatory evidence in violation of the strictures of *Brady v. Maryland*, 373 U.S. 83, 83 S. Ct. 1194, 10 L. Ed. 2d 215 (1963). *Id.* at *4. After Plaintiff was exonerated of a robbery and found not guilty of a murder, he sued the District Attorney's Office claiming that the *Brady* violation was caused by the Office's unconstitutional policy and resulted from the Office's deliberate indifference to an obvious need to train prosecutors in order to avoid constitutional violations. *Id.*

This Court began its analysis by recognizing that a plaintiff alleging that a municipality is liable for failure to train has the burden of proving both: (1) that the municipality and/or its policymaker was deliberately indifferent to the need to train; and (2)

that the lack of training actually caused the constitutional violation. *Id.* at *6. District Attorney Connick argued that the municipality was entitled to judgment as a matter of law because the plaintiff failed to prove that he was on actual or constructive notice of, and therefore deliberately indifferent to, a need for more or different training. *Id.* The majority of the Court agreed with District Attorney Connick's argument.

This Court held that "[a] pattern of similar constitutional violations by untrained employees is 'ordinarily necessary' to demonstrate deliberate indifference. . . ." *Id.* at *8. "Without notice that a course of training is deficient in a particular respect, decisionmakers can hardly be said to have deliberately chosen a training program that will cause violations of constitutional rights." *Id.* The Court went on to hold that the lack of a pattern of similar violations in the past by the Orleans Parish District Attorney's Office prevented the imposition of supervisory liability in *Connick*. *Id.*

This Court discounted the plaintiff's argument that the case fit into the "narrow range of circumstances" wherein a pattern of violations is not necessary to show deliberate indifference. *Id.* The Court discussed the fact that *City of Canton* recognizes the hypothetical possibility, "however rare," that the "unconstitutional consequences of failing to train could be so patently obvious" that a municipality could be held liable without proof of a pre-existing pattern of violations. *Id.* The "narrow range of *Canton's* single-incident liability" was limited to occasions when officials were required to make "split-second decisions with life-or-death consequences," and wherein officers are

unfamiliar with applicable standards. *Id.* The Court held that the duties of the attorneys considering *Brady* evidence simply do not fit into the "narrow range" of the *City of Canton* exception. *Id.* Indeed, the training which attorneys receive sets them apart from the untrained, heavily-armed officers contemplated in the *City of Canton* hypothetical, and the very narrow exception did not apply. *Id.* As noted in *City of Canton*, "in virtually every instance where a person has had his or her constitutional rights violated by a city employee, a § 1983 plaintiff will be able to point to something the city 'could have done' to prevent the unfortunate incident," but the result of the training in *Connick* was not so predictable that failing to provide the training would have amounted to a conscious disregard of constitutional rights. *Id.* at *10.

According to *Connick*, therefore, the circumstances which would permit a finding of liability based on an isolated incident are not present in this case. Even if Plaintiff's allegations that the nurses acted outside the boundaries of their professional obligations were true, such acts would not qualify the present case for the *Tuttle* exception. Because there is no evidence in the Record of a pattern of deliberate indifference to the serious medical needs of inmates which would subject Sheriff Callahan to individual liability, and this case clearly falls outside of the extremely narrow *Tuttle* exception, Sheriff Callahan respectfully requests that the Court deny Petitioner's request for a Writ of Certiorari.

Plaintiff's arguments regarding Sheriff Callahan's supervision and training of the nurses and Dr. Bolin must also fail because there is no evidence that Sheriff Callahan either failed to supervise or train Dr. Bolin

or the nurses. The Record shows that Dr. Bolin and Wichita County entered into an employment contract to which Callahan is not a signatory. The Contract provides, among other things, that Dr. Bolin will supervise jail nursing staff in their professional capacities. (USCA5 p. 3052.) Further, Sheriff Callahan testified in his deposition that Dr. Bolin was responsible for supervising the nurses' provision of medical care to the inmates. (USCA5 p. 3051-3052.) Since Sheriff Callahan was not responsible for training or supervision of the nurses, he cannot now be held liable for any alleged constitutional violation which may have resulted from such failure. *See Gates v. Tex. Dep't of Prot. & Regulatory Servs.*, 537 F.3d 404, 435 (5th Cir. 2008) (holding that a supervisor was not responsible for failure to train absent an affirmative showing that the supervisor was personally responsible for such inadequacies).

Further, Sheriff Callahan is entitled to qualified immunity because no causal link exists between the alleged failure to train or supervise and the alleged violation of Petitioners' rights since Sheriff Callahan did not have a duty to train and/or supervise the medical care provided by the nurses. (USCA5, Vol. 9, Jt. App. P. 34; p. 3052.) Rather, Dr. Bolin was contractually obligated to provide such training and supervision. (USCA5, p.3052.) Since Dr. Bolin was contractually responsible for training and supervision of the professional activities of the nurses, Sheriff Callahan cannot be held liable for any such failure. If such a failure occurred, then such failure was not Sheriff Callahan's responsibility and Sheriff Callahan is therefore entitled to qualified immunity for any such claims.

Additionally, there is no evidence that Sheriff Callahan ever acted with deliberate indifference, and he is therefore entitled to qualified immunity from Petitioners' claims. As discussed more fully above, Sheriff Callahan cannot be held liable in his individual capacity absent a showing that he acted with deliberate indifference. In order to meet this stringent standard of fault, there must be evidence that Sheriff Callahan disregarded a known or obvious consequence of his action. *See Bd. of Cnty. Comm'rs of Bryan Cnty., Okla.*, 520 U.S. 397, 410, 117 S. Ct. 1382, 1391. Specifically, there must be evidence that Sheriff Callahan knew about some objectionable conduct, facilitated it, approved it, condoned it, or turned a blind eye toward it for fear of what he might have discovered. *Gonzalez*, 996 F.2d at 761. In order for Sheriff Callahan to not be shielded by qualified immunity, the need for more or different training must have been "so obvious and obviously likely to result in a constitutional violation" that the failure to train amounted to deliberate indifference. *Id.* Such evidence does not exist in the present case. The Record contains no indication that Sheriff Callahan engaged in any conduct the recklessness of which would deprive him of the defense of qualified immunity. On the contrary, the record clearly shows that Sheriff Callahan's actions were objectively reasonable and did not meet the "extremely high" threshold of deliberate indifference. *See Gobert*, 463 F.3d at 346. The record shows that Sheriff Callahan advised the nurses regarding Dr. Bolin's behavior, instructed them to contact Dr. Bolin whenever they deemed it necessary, and instituted a policy of sending ill persons to the hospital. (USCA5, p.3051-3053.) Additionally, the Record shows that Sheriff Callahan counseled Dr. Bolin to improve his attitude toward the

nurses. (USCA5,Vol. 11, p. 2535.) The presence of these measures undermines any argument Sheriff Callahan exercised deliberate indifference with respect to the training and/or supervision of Dr. Bolin or the nurses. This undisputed evidence shows that Sheriff Callahan did not facilitate, approve, or turn a blind eye toward any conduct which would have violated Brown's constitutional rights. This untroverted evidence shows that Sheriff Callahan did not fail to supervise Dr. Bolin or the nurses, but rather acted as a mediator between him and Dr. Bolin's nursing staff.

In sum, the record shows that Sheriff Callahan's actions with respect to the facts underlying the present litigation did not meet the extremely high standard of deliberate indifference by disregarding a known or obvious consequence of his actions. Clearly, the record shows that none of Sheriff Callahan's actions in the present case could possibly meet this high standard with respect to his training and/or supervision of Dr. Bolin or the nurses. There is no evidence in the Record which would show that Sheriff Callahan knew of any objectionable conduct, facilitated it, approved it, condoned it, or turned a blind eye toward it for fear of what he might have discovered. *See Gonzalez*, 996 F.2d at 761. Therefore, the Fifth Circuit did not err in finding that Sheriff Callahan is entitled to qualified immunity. Sheriff Callahan respectfully requests that the Court refuse to grant the present Petition for Writ of Certiorari.

C. The Record plainly shows that Sheriff Callahan's actions did not meet the extremely high standard of deliberate indifference with respect to his adoption of policies.

In order to state a claim pursuant to § 1983 against an official in his individual capacity for failure to promulgate a policy, "the failure must be an 'intentional choice' and amount to subjective deliberate indifference." *Brumfield v. Hollins*, 551 F.3d 322, 328 (5th Cir. 2008) (quoting *Rhyne v. Henderson Cnty.*, 973 F.2d 386, 392 (5th Cir. 1992)). "In other words, it must be 'obvious that the likely consequence of not adopting a policy will be a deprivation of civil rights.'" *Id.* (quoting *Evans v. City of Marlin*, 986 F.2d 104, 108 (5th Cir. 1993)).

"In addition to culpability, there must be a direct causal link between the municipal policy and the constitutional deprivation. *Monell* describes the high threshold of proof by stating that the policy must be the 'moving force' behind the violation." *Pitrowski v. City of Houston*, 237 F.2d 567, 579 (5th Cir. 2001) (citations omitted) (emphasis added). The Court in *Pitrowski* holds that § 1983 plaintiffs must establish both the causal link and deliberate indifference to federal protected rights so that "where a court fails to adhere to rigorous requirements of culpability and causation, municipal liability collapses into 'respondeat superior liability.'" *Id.*

Here, the Record contains absolutely no evidence which would show that any actions of Sheriff Callahan caused any inmate—including Brown—to have their serious medical needs treated with deliberate

indifference. On the contrary, the Record shows that it was the custom of nurses in the Jail to take inmates to the hospital regardless of whether they believed that Dr. Bolin would have approved hospitalization for the inmate. Indeed, two former nurses testified that they had sent inmates to the hospital when they believed it to be necessary without regard to Dr. Bolin's opinions. (USCA5, Vol 11, J. App. 559,-562; 563-566.) Further, the Record shows that Sheriff Callahan instructed nurses to call Dr. Bolin whenever they needed him and he had drafted a policy which required acutely ill inmates to be transported to the hospital. (USCA5, Vol. 11, pp. 2438, 2510.) The actual policies Sheriff Callahan adopted encouraged nurses to take ill persons to the hospital. There is simply no causal connection between any policy Sheriff Callahan adopted and the events of which Petitioners complain. Therefore, Sheriff Callahan respectfully requests that the Court deny the present Petition for Writ of Certiorari.

CONCLUSION

WHEREFORE, PREMISES CONSIDERED, Respondent Sheriff Thomas Callahan respectfully requests that the Court deny the present Petition for Writ of Certiorari, and for any and all other relief, at law or in equity, to which he has shown himself to be justly entitled.

Respectfully Submitted,

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